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the
MODERN
HOSPITAL

VOLUME 50

APRIL 1938

NUMBER 4

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MORE than 100 surgical supervisors have subscribed to personal copies of *The Modern Hospital* since January. Hundreds of others read somebody else's copy of this and other hospital magazines. This interest in advancing their own technical ability and their grasp of hospital administration is a distinct tribute to the caliber of women supervising surgeries.

For our part we wish to provide them with material that will help them perform their present duties as well as broaden their outlook on the whole of hospital work. For example, they, as well as other nurses and hospital surgeons, will be especially interested in the article by Dr. J. D. Reichard on page 47 of this issue. Doctor Reichard tells some of the methods now used for reducing postoperative shock.

THE hospital number of the *Journal of the American Medical Association*, just published, reports that occupancy in American hospitals last year was at the highest figure ever recorded by the association. Every important category of hospital showed an increase in use.

This growth in occupancy is, as might be anticipated, somewhat uneven. Certain communities still have more than ample provision for the care of bed patients while others have found their overcrowding almost unbearable. An excess of beds 100 or more miles away is of little value to the hospital that finds the demand in its own community greater than its facilities.

As is pointed out in the excerpt from the statement by the technical committee on medical care, printed on page 61 of this issue, there is now a deficiency of about 400,000 hospital beds according to present standards. "Measures to fill this need would include the construction of at least 500 hospitals of from 30 to 60-bed capacity in rural and sparsely settled regions that have inadequate hospital facilities," the committee states.

CONTENTS

READERS of this journal have known of this deficiency ever since a survey of hospital distribution was printed in our March 1935 issue. Efforts to fill present gaps should be intelligently guided. Last month we presented a special section on hospital planning. Next month another special section will be devoted to hospital modernization, and succeeding issues will contain further material on the same subject. In June a special portfolio of floor plans of small community hospitals, with comments by an outstanding hospital architect, will give realistic practical guidance in the construction of the 500 hospitals needed in rural areas.

IT VIOLATES no secret to tell that we have a birthday coming. Next September, *The Modern Hospital* will be 25 years old. For several months now we have been laying plans for our September anniversary issue. We have material scheduled for this issue that will make it, we believe, the most interesting and distinguished ever to appear in the hospital field. Many changes in hospitals and hospital publications have taken place in 25 years. You will smile when you see some of the contrasts that will be depicted next September.

Among those who have already indicated that they will contribute to the silver anniversary number are Dr. Ray Lyman Wilbur, Dr. S. S. Goldwater, Dr. Joseph B. Howland, Dr. Abraham Flexner, Dr. Charles H. Mayo, Dr. Adolph Meyer.

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A consultant in kitchen planning makes a tour of several typical hospital kitchens, points out what is wrong and tells how to right it.

Morale in Mental Hospitals 70

Pointers on maintaining good personnel relations and on obtaining the complete cooperation of the staff by J. ALLEN JACKSON, M.D., superintendent of Danville State Hospital, Danville, Pa.

For Hospital Day Honors 75

An outline to be followed in organizing and collecting publicity for National Hospital Day.

Key Positions 77

The attitude of those hospital employes who meet the public helps to mold public opinion in regard to the hospital, believes JOSEPH C. DOANE, M.D., the editor, who proceeds to show how to keep this opinion favorable.

A Patient's Lament — Part II 79

In the second of two installments, SAMUEL PARLETT reviews his twelve years as a hospital patient and decries the treatment he received from some of his nurses and doctors.

Plant Operation

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A survey of installations and uses, topped off with the opinions of a number of hospital superintendents who have tried out air conditioning for long or short periods.

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A new feature of the oval tank described is complete flexibility, so that turbine and agitator may be moved to any desired position, says JOHN D. CURRENCE, M.D., of New York Post-Graduate Hospital, New York.

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Vancouver General Hospital, Vancouver, B. C., uses a radiant lamp to mark new-born babies and finds this method of identification satisfactory, says the first assistant administrator, R. A. SEYMOUR, M.D.

Housekeeping

Handling Reserve Linen 90

A system that checks the number of articles in stock, keeps tab on the amount used by the various departments and provides a constant supply has been tested by MILDRED BURT, housekeeper at Mountainside Hospital, Montclair, N. J.

Food Service

Food for Child Patients 94

Not variety, but rather the task of presenting familiar foods attractively day after day is what makes the work of the dietitian in a children's hospital no sinecure, declares EVA NORDBY YLVIK, dietitian at the Children's Hospital, Cincinnati.

Equipped for Service 98

And for providing a more varied menu without adding appreciably to the cost is the Miami Valley Hospital, Dayton, Ohio, since it installed several units of new equipment in its kitchens, states ALTA HIRSCH, director of dietetics.

B-D YALE SYRINGES

Made of Resistance Glass

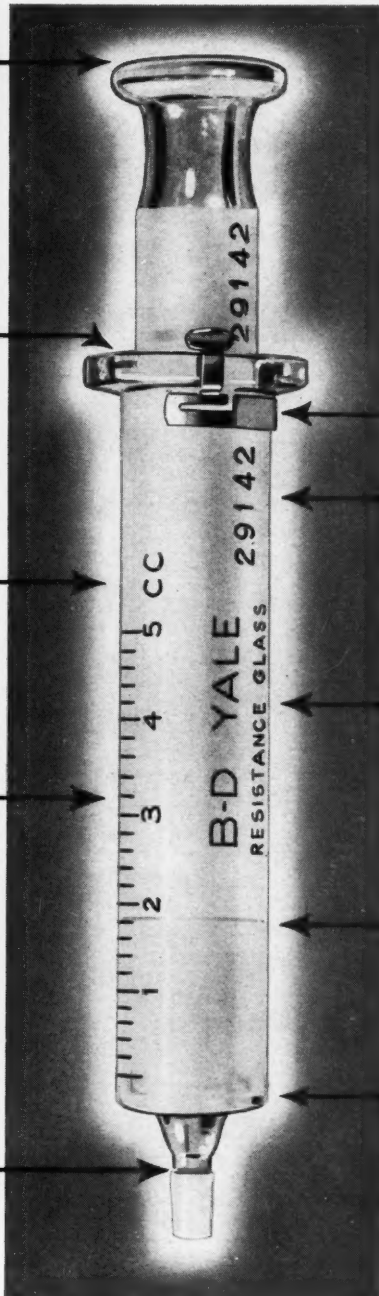
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nate an internal score mark.

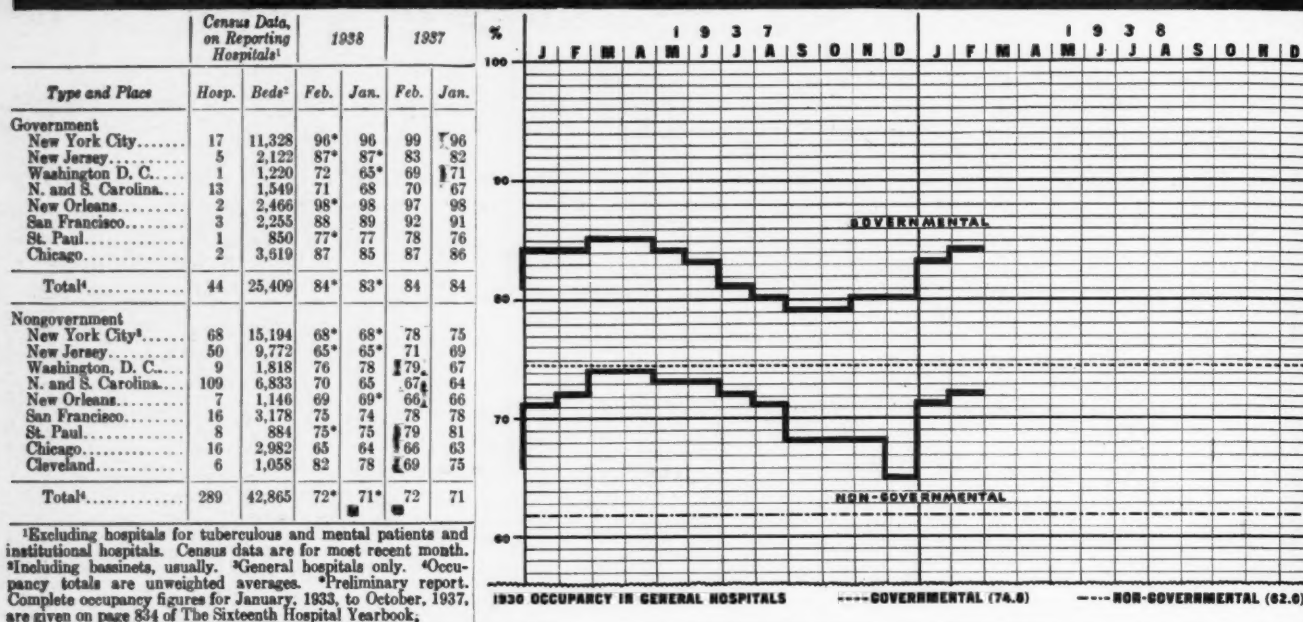
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HOSPITAL OCCUPANCY BAROMETER



Occupancy Slightly Above Level of Previous Month

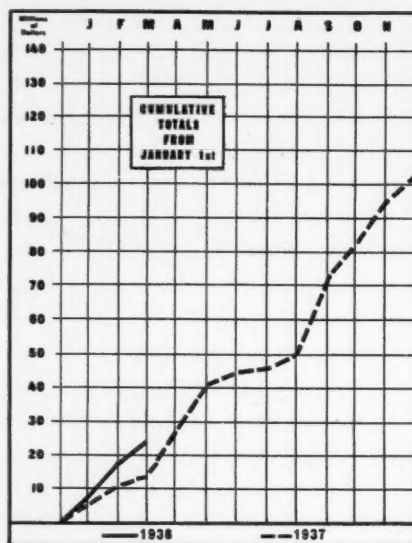
Preliminary occupancy figures for February for the voluntary (nongovernment) hospitals showed a slight increase over January. This preliminary figure is exactly the same as the record for a year ago but when all reports are received it may exceed last year's mark.

The occupancy of government general hospitals stayed at approximately the same level in February as it was in January and the same as one year ago. This is a much lower level, however, than was recorded in the period from 1933 to 1936, inclusive, indicating less overcrowding in government institutions.

The year 1937 was a banner year in hospital occupancy, according to the hospital statistics just published by the American Medical Association. The occupancy of all hospitals, regardless of type of service or control, was at the highest figure ever recorded by the association.

A total of \$5,479,000 of new construction was announced in the period from February 14 to March 14, according to figures compiled in The MODERN HOSPITAL office. There were 25 new projects in all. Six new hospitals will cost \$815,000; one new nurses' home

HOSPITAL CONSTRUCTION



will cost \$70,000. The remaining 18 projects are additions to existing hospitals and will consume by far the bulk of the money, \$4,549,000.

The total reported value of new hospital building projects announced between January 1 and March 14 of this year is \$23,000,000. Last year in the

same period the total was \$16,000,000.

The general price index of the *New York Journal of Commerce* showed little fluctuation in the period from February 21 to March 21, standing at 78.8 on the former date and 78.4 on the latter. (1927-29=100.) Grain prices continued to drop, however, sliding down from 75.3 to 72.4 during the period. The general food index, on the other hand, showed a slight rise, from 67.7 to 68.1. Textiles and fuel dropped slightly.

The trend in building material prices is rather interesting. On March 21 the index stood at 95.1, by far the highest of any of the indexes regularly reported in these columns. While a month earlier it was at 93.8, a year earlier it stood at 104.9. During the past 12 months this index reached a peak of 112.2 for the week ending May 3, 1937, from which it slid continuously downhill till the week ending March 14, 1938, when it reached a two-year low of 93.1.

The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* made another microscopic drop in the period under review, going from 180.8 to 180.1.

Announcing the New Cyclopropane Cylinders



STYLE "AA"

(Tare Wgt. 2 Lbs. Approx.)

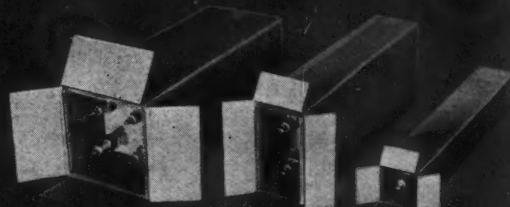
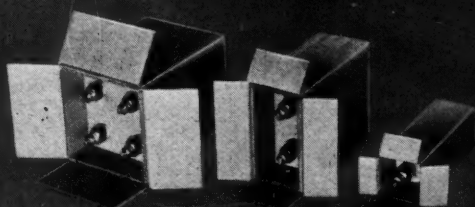
MADE IN ACCORD WITH I. C. C. SPECIFICATION 4-B-300

SUPPLIED IN CARTONS AS SHOWN BELOW



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permit the use of attractive, *lightweight shipping cartons*. It is important that these new cylinders be used only for Cyclopropane. To differentiate them from cylinders ordinarily used for Ethylene, Nitrous Oxid, Oxygen, and Carbon Dioxid, they are *smaller in diameter* and *chromium plated*. Prices remain the same as charged for the older styles.

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THE EDITOR Talks It Over

Outside Maintenance

• The time for spring house cleaning has arrived. If hospitals have been permitted during busy winter months to become dingy and walls are in need of washing or painting, now is the time to correct these defects. Perhaps the hospital is considering the advisability, because the winter has been long and labor troubles have been irritating, of buying cleaning services. This practice appears to be growing in popularity. Companies are springing up that offer to maintain the hospital in a sanitary condition at a price that is often attractive. Many administrators see in this plan relief from many difficulties incident to housing a large number of employees.

Specifications, however, should be carefully drawn since the hygienic requirements proper for a hotel certainly will not be satisfactory to a hospital. Before changing the system, the hospital should consult those with experience in the new plan. Proper daily inspection by a qualified person is of the highest importance.



For the False Few

• Do you require a definite diagnosis from a referring physician before a patient is admitted? Some hospitals do. In some instances such a rule appears necessary. But the adoption of a stringent rule immediately casts doubt upon every member of the staff. It suggests that some physicians admit a case of venereal disease, for example, under the diagnosis of a chronic heart ailment, or certify that a chronic hemiplegic patient is acutely ill in order to relieve the family of a burden.

Physicians are sometimes tempted to obtain entrance of troublesome patients into a hospital ward. On the other hand, the doctor may not be in position to give a diagnosis. In telephoning from the residence of the patient he may not care to state his suspicions in the hear-

ing of relatives. Some hospitals accept a "for study" diagnosis.

Whatever the rule, physicians who falsify diagnosis should be dealt with individually. The whole staff should not suffer as a result of the dishonesty of a few.



Going to Market

• Telephones may be harmful instruments in the hospital when they are employed as a substitute for a trip to market. Buying by telephone is physically easy, but this practice also facilitates extravagance on the part of the hospital.

It is surprising how often, even in large institutions, the purchasing agent buys by phone or as a result of a visit of a salesman. Going to market is apparently passé.

Busy dietitians assigned to the purchasing of food may find it impossible to supervise kitchens and at the same time purchase food products. The fault here lies with the administrators, who require such impossible services. The purchasing of drugs by telephone certainly will lead to losses. To buy them from salesmen without competition is equally extravagant.

Marking Birthdays

• Birthdays are happy occasions. How often do hospitals remember their own birthdays and mark them in some suitable fashion? Perhaps a special menu might be used on such a day. Recounting a hospital's progress and accomplishments in a meeting of the board of trustees would be suitable on that day. Birthdays of the founder of an institution, of an outstanding superintendent of nurses who died in service or of some other person who contributed greatly to the hospital's success might also be observed.

Often the hospital busily plodding on its way is analogous to the ill-fated Arc-

tic explorer who, believing he was trudging southward at the rate of ten miles a day, was being carried northward fifteen miles a day by the movement of the Arctic pack. All institutional people might well pause occasionally and note in which direction and at what speed the hospital is traveling.

Bedside Manners

• It would be interesting to evaluate today's bedside manners. What is appropriate as a topic of discussion in the drawing room may hardly fit the sick room in the hospital. To discuss disease or to enter into heated arguments as to morals or politics appears much out of place in the hospital. Indulgence in personal remarks or in petty gossip, sitting on beds and comparing the fine points and failings of staff doctors are not, sad to relate, practices of a past generation. Classes in bedside manners might also include practical demonstrations as to the most efficient method of carrying out the commonest of all procedures, the giving of a bed bath.



A Place of Health

• In childish and even in adult minds the hospital too long has been a place of terror. The opinion of many has been that it is an institution in which the odors of iodoform and of ether are mingled with the cries of suffering.

Today, thanks to well directed publicity, the public largely views the hospital as a beneficent institution where there are light and sunshine and joy even though these are too often mingled with disappointment and grief. The rising generation has learned that in its out-patient department it will find children's clubs where moving pictures and kindly and entertaining doctors, nurses and social workers teach the science of healthful living. The hospital must strive more and more to represent a place of health as well as one of disease. More prevention will surely mean less disease and suffering.

LOOKING FORWARD

Selling Doctors' Services

A GREAT cry has arisen in some localities over hospital care insurance plans because, it is said, such plans propose to retail the services of the physician. This is particularly true of such specialties as x-ray, laboratory, physical therapy and electrocardiography. Demand has been made that these services be excluded from group insurance plans. Recently in certain commonwealths laws have been introduced forbidding under penalty the selling of doctors' services.

If there is anything immoral or unethical in including in hospital rates the service of physicians there must be a complete reorganization of our whole institutional structure. Splendid hospitals with full-time salaried staffs must liquidate. Such institutions must throw open their doors to community physicians and the physician must obtain his recompense only from patients' fees. Great clinics that collect all patient fees at the cashier's window and pay the stipulated honorariums of the physicians can no longer function. These surely are selling the services of physicians.

If, on the other hand, such splendid institutions are permitted to exist and are pronounced ethical, then the same principle must hold true wherever hospitals are conducted and physicians practice. There can be no double code. What is right in the Midwest or Far West is equally right in the North or East. Provincialism may be employed locally only if the public is not informed.

Au Revoir

MANY well managed hospitals have a strict rule that no patient, relative or casual visitor shall leave the institution disgruntled. Every possible effort must be made to treat the patient with such tact, intelligence and kindness that he will remember the institution with gratitude.

Why? Is it worth while to have words of praise from former patients? Do the opinions of people who have actually been served by the institution carry special weight in the community?

Obviously they do. If good words from former patients are worth cultivating, are not good words from former employees even more valuable? Surely

when a nurse, a housekeeper or a janitor says, "Yes, I used to work at the Community Memorial Hospital," his auditors will feel that at least he knows what spirit animates the institution.

When hospital employees are discharged or resign they do not ordinarily disappear. They continue to live in the community and to discuss from time to time the hospital for which they once worked. Whether this discussion is resentful or friendly depends upon the treatment they received.

It should be an inviolate rule that no employee leaves the hospital, either by resignation or discharge, without an "exit interview" with the administrator, the personnel manager or some other executive. When an employee is discharged or resigns because of dissatisfaction, the administration has failed somewhere. It is important to find out where and why this failure occurred. A frank sympathetic talk with a departing employee may reveal more to a discerning administrator than he can learn through many weeks of direct observation.

The training of every employee represents a definite cash investment on the part of the hospital. This investment should be protected against unnecessary loss as vigilantly as any other of the hospital's investments.

One progressive midwestern hospital not only utilizes exit interviews but in addition pays terminal vacations when earned. The administrator and the trustees maintain stoutly that this is a sound investment in community good will. This hospital is building a steadily enlarging circle of loyal friends.

Whether regarded as a part of the public relations program or a sound system of personnel administration, the exit interview is a valuable tool too frequently neglected by hospitals.

Braces by Prescription

FEELING that the counter prescription of braces constitutes a serious abuse of an important field, the American Academy of Orthopedic Surgeons has appointed a special bracemakers' committee. This committee is composed of the following physicians: Dr. Philip D. Wilson, New York City; Dr. Joseph S. Barr, Boston; Dr. Hugh T. Jones, Los Angeles; Dr. Joseph H. Kite, Decatur, Ga.; Dr. Fritz Teal, Lincoln,

Neb., and Dr. Mark H. Tibbetts, Duluth, Minn. It is the committee's purpose to attempt to constitute braced makers as a guild with a distinctly professional attitude. One of the principal objectives is the development of better cooperation between manufacturers of braces and the surgeons who use them. For a surgeon to send a patient to a braced maker without prescribing the character of brace is about as logical as sending him to a pharmacist for "some medicine."

As may be seen from the pictorial presentation on pages 52 to 53 of this issue, braced making is a highly skilled profession. As such it deserves a place of dignity and importance in the scheme of things medical. It will achieve this most readily when all braces are made on prescription.

Discharging the Patient

ON PREVIOUS occasions in these columns we have stated our opinion that the discharge of a ward patient from the hospital is an administrative matter, in which the policies of the hospital are vitally involved. When the members of the visiting staff come to the decision that a patient is to be discharged they naturally expect that the process will be automatic and immediate. Some medical men are impatient with the ways of the social service department which does, indeed, act as the administrative arm in carrying out such decisions. That arm happens to be a gentle and protective one, built for defensive purposes only. The social worker may, as a rule, be counted on to do her best not only because the patient no longer requires the use of a bed in the ward but because she knows that there may be others requiring hospitalization waiting for the same opportunity.

How many men on the visiting staff are willing to consider urgent social factors in their decisions? How many consider their duty done when the patient seems to them to be safely on the road to clinical recovery? We might examine the situation from a number of social and medical points of view. For example, who has the final clinical word in the decision to discharge a patient, apart from the executive office of the hospital? Since the chief of the division or senior attending physician is the responsible officer for the conduct of his department, it would be reasonable to expect his signature of approval in every instance where it is desired to discharge a patient who has been under his supreme management. Under the system of uniting the activities of the in-patient and out-patient departments, which most progressive hospitals employ, it is reasonable to expect that no patient admitted from the out-patient department will be discharged to that department unless the chief of clinic, who saw him in the first place and to whom he is to return, has been informed of the intent of the visiting staff.

A patient may be under treatment in one of the special therapeutic departments of the hospital. How careful is the visiting staff to consult with the special therapist before the recommendation to discharge is put through? Take the dental department, for instance. It should be clear that no extensive dental work should be undertaken without close cooperation between this special therapeutic department and the visiting staff. How many visiting men remember that patients transferred from one service to another for special treatment should be retransferred to the original service which is expected to follow the patient after his discharge from the wards? How prompt is the visiting staff to inform the social service department when a patient is ready for discharge so that the routine of discharge may be expedited and necessary follow-up arrangements made in an unhurried way and without loss of time? Patients must be prepared for discharge over a reasonable period of time.

While the pressure of a waiting list may be great, the administrator must keep in mind that his first duty is to the patient for whose care he has accepted responsibility. It seems obviously unfair to the patient, who is still sick enough to be in the hospital, to hurry him out of the wards prematurely because another patient is waiting to come in, unless the situation in the community is such that only these two alternatives remain, in which case the hospital must still consider its responsibility of seeing the patient through his illness.

Fatigued Nurses

PHYSICAL and mental fatigue makes for inaccuracies and inefficiency. The proponents of the eight-hour day for nurses rightfully point out that at the end of long hours of duty the nurse's response time is lengthened and that her judgment is less reliable. In reading orders and measuring dosage she is more likely to err. This applies particularly to those who are caring for the acutely ill.

All nursing assignments are not equally demanding, however, and in many instances nurses serve more as companions than as nurses.

There must be a reasonable balance. Surely nursing will not gain public esteem by talking too long or loudly of hours of duty, of length of vacations and of the physical perquisites incident to living. The more militant nurses have adopted the radio to force action on their demands for shorter hours, declaring that a forty-four-hour week should be set as the maximum.

Many hospitals are embarrassed by financial demands and at the present time simply cannot meet a further large increase in nursing expense. Some hospitals have adopted three eight-hour tours of duty for the nurse for which she is paid a flat fee, the hospital providing

one meal a day. This arrangement should meet the requirements of the acutely ill and avoids the danger of mistakes due to fatigue.

Thousands of ethical nurses working in the nation's hospitals have shunned alignment with nonprofessional groups and are carrying on with the full knowledge that hospital trustees and the public itself are keenly interested in their problems and that a solution will be spontaneously brought about as soon as it is economically possible. Cries for a forty-four-hour week by a militant minority will achieve little.

Who Should Yield?

DOCTORS often desire to perform dressings or make rounds at meal time. Hospital nurses wish to serve food when it is at its best. Who shall yield? There is but one solution to this problem—the accomplishment of the largest good to the greatest number. The hospital cannot survive that alters its rules to suit the personal desires of every physician, nurse or technician. The whole must govern the part. Unless personnel is available to serve food on an individual basis, it appears reasonable to require that, except in an emergency ward, meal hours should not be devoted to ward classes, dressings or the making of rounds.

Problem in Organization

THE great physician working in the hospital is not always a great administrator and, at times, he is not even a good one. The ideal type who is clinician, teacher, investigator, administrator and all-round human being is as rare as some of the diseases which only he is able to handle so masterfully. Every hospital executive has had occasion to wrestle with this problem at one time or another, but not many have found the practical way of extracting the best out of each clinical chief, while making allowance for the remainder.

One can willingly go beyond the mere toleration of defects for the sake of outstanding talents and plan the organization so that the greatest good may come to the greatest number by giving specialized tasks to men with selective interests.

Even in those cases in which the clinical chief happens to be a good executive it may not be advisable to burden him with paper work and administrative routine. Many chiefs of division deputize members of their staff for special purposes. Thus, one junior officer may be assigned to supervision in the admitting room; another may become liaison officer with the special departments for diagnosis and therapy, or with the social service department, or with the administration of the hospital; a third may be assigned to organize clinical conferences and draw up schedules.

One large hospital in the East has experimented successfully with the appointment of an "administrative officer" on an informal basis, the appointment coming from the chief of division rather than from the governing body. Such an appointment provides an interesting opportunity for a junior member of the staff who has administrative gifts. He makes it possible for his chief to do those things that he can do best, while freeing him from routine duties that would otherwise cramp his style and be an unnecessary burden to him.

With the senior and junior officer working hand in hand on a basis of sympathy and understanding, a desirable scheme of organization has been worked out which may be safely adopted elsewhere.

The Eight-Hour Day

THE administrator who agrees "in principle" with the eight-hour day and then starts worrying about the financing of such progressive legislation in his hospital soon learns why it is that he personally is so kindly exempted from its provisions. A thorough-going job analysis of his position has not yet been attempted successfully with any degree of finality and there is some ground for believing that it never will. He is administrator, coordinator, statesman, physician, social worker, lawyer, engineer, hotel keeper and accountant all in one and knows the meaning of responsibility, especially when responsibility overbalances the authority that is conferred upon him by his board of trustees.

The man who takes orders and is in a position to "pass the buck" or complain to someone higher up is, in a sense, more fortunately situated than the one to whom he unburdens himself. The administrator taking his lunch at the hospital may think in his heart (or is it his stomach?) that the food is poor but, if he has a sense of humor, he may rightly complain that he is at a disadvantage because he is left literally holding the bag.

The man hanging out on a limb of the administrative family tree has some compensation in the eight-hour day which is denied to the man at the top who, as head of the family, does all the worrying for his brood. The man who may need it most and could least be spared is the one whose working time must not be curtailed. His most difficult tasks, those which are extramural and extraroutine, must often be accomplished after "working hours," so to speak. The notebook at the bedside of the hospital administrator testifies to the fact that he also works while he is supposed to be sleeping.

The more abundant life may some day confer its benefits on the hospital administrator, too, but that may not come until men will recognize that shorter hours mean longer years for him, as well as for those who take direction from him.



Softening Bleak Exteriors

DAVID C. FAIRBURN

WITH careful planning there is absolutely no reason why a hospital exterior should look bleak and uninviting. Of course, some institutions have been erected in congested areas in which there is scarcely room for a blade of grass, much less a garden. Hospitals should be located in the open spaces where there is plenty of room for beautiful lawns, trees, shrubs, gardens, tennis courts and swimming pools. A pleasant atmosphere is extremely desirable, not only for the benefit of the patients but also for the staff.

The purpose of this article is not to outline in detail any of the various phases of landscape design, but rather to indicate in a general way what might be done to make hospitals more livable.

Planning is the most important feature in the development of any property. The buildings, walks, drives, lawns, gardens, terraces and plantings must be arranged to form

a balanced picture that is both pleasing to the eye and efficient. This requires skill. As a general rule nurserymen and gardeners are not qualified to attempt such a project. A small fee to a well-trained land-

scape architect is by all means a sound investment.

The hospital should not be jammed on a small city lot where it will be hedged in by other buildings. Let there be plenty of land to

Simplicity of design and careful grouping of flower plots characterize the small informal garden above. Below is a fine new building in need of landscaping.



be planted and developed as an appropriate setting. If the building is erected on the crest of a hill, the patients can spend many interesting hours enjoying the vistas.

Considerable space is needed in front of any large building to present the property as an architectural unit. The building, of course, should dominate the landscape, but also harmonize with it.

Nothing is more appropriate for the front area than a long sweep of well-kept lawn with the building in the background framed by trees and shrubbery. Flower beds and specimen plantings scattered at random on the lawn spoil the general effect.

Secluded from the street, the stretch of shaded lawn below is used by patients as an outdoors living room.



Vertical lines of the evergreens carry the eye to the fine architectural details of the hospital at the right and enhance its beauty. Below: The fountain is the focal point in this patio.



In foundation planting trees and shrubs should be used as a frame, with the building as the center attraction. The character of the plantings depends on the style of architecture. Plants used to advantage with



a stone building would not make a good setting for one with a stucco finish. The selection of plants for foundation arrangement is like choosing furniture for a room. Balance and harmony are essential. With plants it is also necessary to know their habits of growth, for as the trees and shrubs develop into mature specimens, the scene may change radically. Frequently plants are crowded close together to produce an immediate effect and when they grow larger the arrangement becomes a tangled uninteresting mass that eventually has to be rooted out. As a general rule shrubs when planted in a group should be spaced one-half to two-thirds of their full-grown height apart. Planting distances for trees range from 10 to 40 feet apart, depending upon the kinds used and the effect desired.

Grouping for Effect

Trees and shrubs grouped at the corners soften the lines of the building. The main entrance can be emphasized by placing prominent shrubs and trees of a small slender nature on either side. If the foundation of the building is not attractive, the planting can be made continuous to hide it, but ordinarily a few open spaces exposing the foundation add tremendously to the character of the planting.

The drives and walks must be arranged primarily for convenience, secondarily for beauty. Serpentine effects are both futile and ugly. Straight or gradually curving lines are most acceptable.

The areas at the back and sides of the hospital should be more private. If necessary, tall boundary plantings of trees and shrubbery may be used to block off objectionable views of adjacent buildings.

The first consideration is a service driveway leading up to the rear door or to the side. If the property is small, the drive should be placed to one side, not in the center, where it will slice the area in half. Trees lined along the driveway provide most welcome shade on hot days.

Flower gardens are best located at the back or at the sides of the building, depending on the contours of the property. They may be large or small, but certainly they should be

private. A garden is a retreat where enjoyment and relaxation are expected. Therefore, it must be isolated from obnoxious views and screened from the public. An effective way to obtain privacy is to surround the garden with trees and shrubbery. A tall vigorous hedge, if left untrimmed, will often suffice. Stone walls and fences are other features of value if used properly.

There are no stereotyped designs for the flower garden. It may be formal, informal or a combination of the two. A garden becomes more interesting if some originality is shown in the design. The informal type is most popular and possesses a naturalistic simplicity usually lacking in elaborate formal gardens.

A large plot of well-kept lawn makes a splendid central feature for an informal design. Flower borders with shrubbery as a background, a small pool containing water lilies and a comfortable seat in a shady corner might well complete the picture. A small garden can be just as attractive as a large pretentious one. It is well to keep in mind that planning is more important than planting. First, decide what the design is to be and then select the proper plants to make the picture.

Why Not a Rock Garden?

Rock gardens are now in vogue and they can be made especially attractive if located on an embankment or in a ravine. A miscellaneous pile of geological curiosities interspersed with a few straggling plants will never win any blue ribbons. On level ground it is wise to use other forms of gardening. Falling water is fascinating and restful. It is best when tumbling down over rocky ledges. This feature can be accomplished by running a concealed pipe or garden hose to an elevated ledge so the water will appear to come from a spring.

Even though a property is well landscaped, it will give only temporary pleasure unless properly maintained. A neglected garden soon looks wretched. Lawns must be mowed regularly and fertilized about twice during the growing season to keep them in good shape. A light dusting of ammonium sulphate, sodium nitrate or some other fertilizer

high in available nitrogen stimulates growth. A light mulch of fertile soil carefully scattered over the lawn twice a year will benefit the grass. Weeds can be eradicated by hand or by chemical treatment. Hand weeding is tedious, but final. Do not use lime on lawns unless it is needed. Have the soil tested first to see if it is too acid.

Trees and shrubs may require pruning occasionally. Dead or broken branches should always be removed, but do not run "hog wild" with the pruning shears. We see too many examples of butchery masquerading under the heading of pruning. Plants need fertilizing regularly. Volume 22, number 4, of the Missouri Botanical Garden Bulletin contains valuable information on the feeding of shade trees. Shrubs will not require as much feeding as trees. The fertilizer can be scattered on the surface of the soil and turned under.

Care of Flower Borders

The flower borders should, of course, receive direct sunlight, otherwise the plants will never grow properly. A bit of fertilizer stirred into the soil around the plants will keep them looking well. In dry weather the flower beds will need plenty of watering. Remove faded or dead flowers and spray the plants if insects and diseases are present. Edge the borders frequently to prevent the grass from encroaching on the flowers and vice versa. Weeding and cultivating are essential items. When selecting plants here are a few things to keep in mind:

1. Size: How large will the plant grow eventually?
2. Form: Is it spreading, upright or prostrate?
3. Texture: Are the leaves and twigs coarse or refined?
4. Color: What color are the leaves, bark and flowers?
5. Growth Requirements: Does the location demand a plant that will have to tolerate shade or sun, dry or moist soil, acid or alkaline soil, heat or cold?

Before buying plants, decide what is needed and where each is to be used. Consult an experienced landscape architect or someone who knows the value and technic of appropriate planning.

Preventing Psychic Shock

J. D. REICHARD, M.D.

ACCUSTOMED as physicians and other hospital personnel are to diagnostic and operative procedures, they are likely to forget how much anticipatory anxiety is suffered by patients before these procedures are carried out. They are usually not aware of the cost to the nervous system of a patient who maintains a brave front and are not always trained to realize that emotions of fear and anxiety, especially when sternly suppressed, reverberate throughout the body and cause profound physiologic abnormalities, especially in the circulatory and neurovegetative systems.

The preoperative patient who is obviously and thoroughly demoralized usually gets careful treatment, but the patient who has been trained to repress nervousness and to pretend indifference to anxiety is generally overlooked. When a person of this type faces a procedure that frightens him, he usually goes through it without difficulty, but frequently a repercussion follows. An example familiar to all is that of the big burly athletic type of individual who faints after a vena puncture.

Many of us have had a similar experience. One may face a sudden dangerous situation and react to it adequately, but later develop extreme nervousness, circulatory collapse or even syncope.

Masked or latent neuroses are not uncommon. These persons appear to the casual eye as normal. They may be thought of, if known well, as a little nervous, or perhaps short-tempered or irritable or prone to worry, depending on the type of neurosis that is under control. These people are frequently the real "producers" of society. They have a drive which is being utilized in a socially acceptable and valuable manner, with some cost to themselves, but not sufficient to be considered as "neurotic."

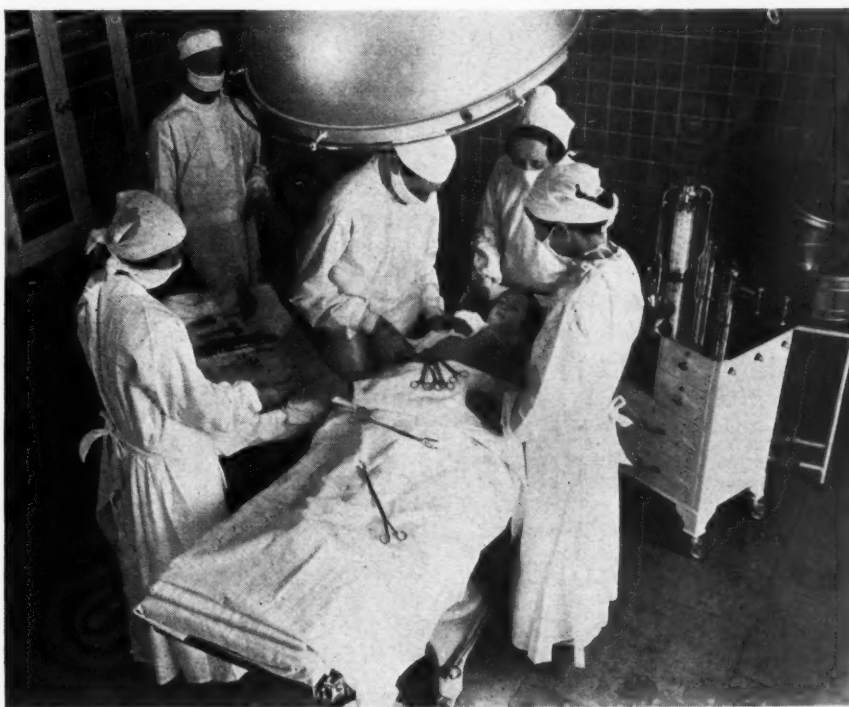
A note on the prevention of emotional complications of surgical procedures is given here by the senior surgeon of the U. S. Marine Hospital, Ellis Island

Now, if a tense, worried individual has to look forward to some diagnostic or operative procedure, the wear and tear on his circulatory and autonomic-sympathetic systems is much greater than that of a poised, placid personality. Sometimes a procedure that causes anxiety both before and during it may precipitate a full-blown neurosis. I recall such a case in which the psychic shock of an intraspinal anesthesia and the feeling that the lower part of the body was gone resulted in prolonged psychic invalidism for the patient.

A procedure that, though relatively painless, calls for active or passive cooperation and carries with it a threat against the patient's idea of his own bodily integrity is a potential source of profound emotional disturbance.

Two examples of this are tonsillectomy and lumbar puncture. The former, to the patient, is a threat against his air supply; the latter brings in a lot of fanciful ideas about dangers of paralysis, which have definite force as psychic traumata.

There is a class of patients who are entirely willing to cooperate, but whose anxiety produces so much nervous tension that they cannot. Dentists meet this type frequently. "The spirit is willing, but the flesh is weak." The patient wishes a tooth extracted or filled, but the hand almost automatically pushes the operator away. Usually, if the physician exercises his persuasive powers to the utmost, the goal is attained, but the energies of both operator and patient



Use of sedative drugs is a safe procedure for taking a patient through necessary surgical operation with little danger of psychic shock or emotional shift.

are exhausted, and much valuable time is consumed.

Surgeons have reported that post-operative shock and mortality are much higher when the patient is not protected in some manner from psychic shock preceding and during operations. The matter was first forced on the attention of the profession by toxic goiter patients with whom elaborate subterfuges were resorted to in order that the patient would not know the day on which the operation was to occur. "Basal anesthesia" has been worked out as a recognition of the damage caused by preoperative anxiety, and it has been found that this procedure reduces the number of postoperative complications.

Using "Psychic Buffering"

These facts are a strong plea for the wide extension of this idea and the visualization of the procedure as a psychic analgesia or "psychic buffering." Just as a buffer salt in a solution prevents a sudden change in hydrogen ion concentration, so the skillful use of sedative drugs prevents a sudden and harmful, even fatal, emotional shift.

The ideal preparations for this work are the barbiturates. There is a wide choice of compounds. The important point is to select one's drug and to become familiar with its behavior. Pursuit of new and more complicated compounds is futile and expensive.

"Psychic buffering" should be a prophylactic and not a curative procedure. The prevention of psychic shock is easy; its treatment sometimes difficult. The need for prophylaxis must always be borne in mind, and it should be resorted to on the slightest indication. If an operation has to be looked forward to for a day or two, sufficient sedation should be given to ensure sound sleep. If the need for the procedure arises suddenly, it is advisable to give a sedative as soon as possible; an hour before, when time permits.

If time of administration and dosage are well selected, a mild euphoria similar to mild alcoholic intoxication can be obtained. In this state the psychobiologic unit seems especially resistant to both physical and psychic traumata. The amount of anesthetic,

whether local or general, is greatly reduced, and moderate pain or discomfort are well tolerated. The post-operative condition and convalescence are more satisfactory, and the risk of precipitating a prolonged demoralization is lessened.

This can be illustrated by the experience with encephalography at the U. S. Marine Hospital, Ellis Island, N. Y. Before the institution of a planned "buffering" procedure, post-operative encephalogram patients suffered intensely, sometimes became maniacal, and always were placed in a separate room for several days to avoid the disturbance to other ward patients. Since the use of the procedure, all this has most dramatically stopped. Fall in blood pressure and shock symptoms sometimes encountered during air injection are rarely seen; and the patients, although uncomfortable after the operation, are quiet, tolerant of their discomfort and can be cared for on the open ward.

The procedure is simple. A dose of the sedative used is given the night before and repeated one hour before the operation. Then a small dose of morphia is given immediately before the encephalogram. Post-operatively a hypodermic barbiturate in small doses is used for a day or two, as necessary. The amount of postoperative sedation used has been greatly reduced since the initiation of the preoperative preparation.

A Headache Preventive

Postpuncture headaches are the bugbear of neurologic practice. They are undoubtedly organic in origin, but just as undoubtedly their frequency is affected by the emotional tone of the patient previous to the puncture. Kulchar and King have reported that patients who are "buffered" prior to puncture have a lower incidence of headaches than those not so protected. This has been confirmed by our clinical experience.

Stokes has recently reemphasized the need for the procedure, and recommends as a routine the administration of a sedative before lumbar puncture is done.

In urging such a procedure, we are not leading the nonpsychiatric reader into any mysterious realm of emotions existing *in vacuo* and bom-

barding the body somewhat after the manner of cosmic rays. Some experimental work has been done which suggests that "buffering" rests on a sound physiologic foundation. Yakovlev concludes, on experimental evidence, that the hypothalamus and the adjoining portions of the brain represent a headmost ganglion of the autonomic nervous system which controls or influences the functioning of the whole nervous system. He compares this region with the sino-auricular node and regards it as a pacemaker for the cerebrospinal nervous system.

Sedative Reduces Fear

Masserman has gone further. Working with cats, he found that minimal faradic stimulation of certain areas of the anterior portion of the hypothalamus of unanesthetized animals produced motor and sympathetic reactions resembling those associated with the emotions of rage and fear. These reactions appeared also when the animal was under light ether anesthesia. However, after the intravenous or intraperitoneal injection of sodium amytal (from 20 to 50 mg. per kilogram of body weight), these motor and sympathetic reactions are diminished or abolished.

It seems probable, therefore, that the action of a sedative in reducing anxiety and fear is, at least in part, a specific physiologic function, viz. a decrease in the irritability of the hypothalamic region, thus creating a block to the conversion of unpleasant psychic states into disagreeable and dangerous bodily expression.

There are two good reasons for the routine use of preoperative sedation. The first may be regarded as important from the point of view of the physician and his staff. The patient is more cooperative, has a better attitude toward the procedure and gives less trouble afterward. The second, and by far the more important reason, is that there is available a simple, safe procedure, by which the surgeon can, in certain cases, prevent or postpone the development of a neurosis, or in cases in which a neurosis is present can carry the patient through necessary surgical procedures with a minimum of psychic and physiologic shock.

Next in Insurance Plans

S. S. GOLDWATER, M.D.

IT IS a matter of rejoicing that the hospital care insurance plan in New York City has grown to the point at which it claims 600,000 members or more. That is a proud achievement and far beyond the expectations of those who gave this plan its first impetus.*

That so much has been accomplished is due in part to the essential decency and honesty of the plan itself, to the fact that it arrived at an opportune moment, that it filled a longfelt want, that the operation of the plan fell into hands of an able and sincere board of trustees who were seeking nothing for themselves, nothing for their hospitals and nothing directly for the medical profession, and also that the organization was lucky enough to obtain a brilliant executive in Frank Van Dyk.

Lightening Taxpayers' Load

The group hospitalization plan locally has undoubtedly prospered. On the other hand, its prosperity has not given me, at least, complete satisfaction. I am in a sense a competitor of the group hospitalization plan. The plan is serving 600,000 people in New York City. As commissioner of hospitals of the city of New York, I represent a much larger plan. Three hundred fifty thousand persons in the city receive hospital care as in-patients each year at the expense of the taxpayers of this city. Assuming that they represent a population ten times as great, the city of New York today has in its hospital service plan for the medically indigent 3,500,000 nondues-paying members.

I am anxious to transfer part of that load to the Associated Hospital Service. The questions are: Can it be done? If so, in what manner? What powers and ideas need to be

invoked to put through the expansion plan that I have in mind?

Members of Group A are not eligible for admission to group hospitalization membership because their means are such that they can take care of themselves as individuals.

Group B includes the persons of moderate but regular incomes who are not able to meet the excessive and disastrous costs of unexpected illnesses. That group is provided for, at least so far as its costs of hospital care are concerned, in the existing plans in New York and other cities.

And then there is Group C, persons in this trying world still happily blessed with employment of some sort but with incomes so low that they and their families cannot subscribe to the present group hospitalization scheme and meet in addition the cost of professional service that is a necessary incidental, but is not covered in the plan itself.

Finally, there is Group D, the medically indigent group, which includes today 3,500,000 persons or more in the city of New York, but which also takes in many who might under happier circumstances be transferred to Group C.

I am particularly concerned with two possibilities: (1) rounding out so that it shall do its full job, that which is now being done to a limited extent for Group B, and (2) giving the benefits which Group B persons

now receive through group hospitalization to a considerable number of persons in Group C.

The latter group is not joining the hospital plan in New York today because the plan is honestly represented to them. They know that even if they are able to pay the fee which is charged for membership, they will not be in a position to pay for a surgical operation when it is required. Occasionally an individual, knowing that he will not have such means does join the plan, and in those rare instances medical men are asked to contribute their services. Happily so far they have shown a generous disposition to do so.

Aid to Self-Respect

But the large number of persons who fall in Group C need to be organized in such a way that they can take care of themselves and be shifted from the class of reluctant medical indigents to the class of self-respecting medically insured persons, at least as far as hospital care is concerned. I shall never be happy until that is done. There are at least a million people in New York City that in their hearts today hope that it will be made possible for them to join such a plan to remove themselves once and for all from the group of medical indigents.

If that is done means have to be provided for it. It would be foolish to dogmatize on the subject but in order that we may think of a possible plan in concrete terms, it is necessary to hazard some guesses as to cost and means. That I now propose to do.

I assume at the outset that the group of which I speak, persons who are employed but whose incomes are not sufficient to enable them to get the benefits of the existing plan, numbers at least a million people in the city of New York today. I know, as a matter of fact, that a large number of that group are most reluctant to enter the city hospitals as charges

The commissioner of the Department of Hospitals, New York City, asks that medical service be added to hospital care in the insurance plans that now exist, in a manner consistent with medical ethics

*Adapted from an address to the national convention of Hospital Service Plan Executives, New York, February, 1938.

upon the community. I know that a considerable number of them are unwilling to enter the free public wards of voluntary hospitals because they don't like what they regard as the "taint of charity," and yet it does not lie within their means as individuals, having formed no group, having no collective resources, having no means of budgeting the costs of hospital care, to remove themselves as individuals from the medically indigent class.

If I am right in assuming that that group could pay for hospital care combined with medical care approximately what is now being paid by the Group B class for hospital care alone, namely, \$10 a year, then some means must be found by which that inclusive service could be rendered at such a cost.

Obviously, if out of that cost, we have to find a hospital maintenance fee and a medical service fee, sacrifices have to be made. Let us assume that out of the money that this group would pay in after deducting expenses and reserves, there would be approximately \$7 a day available for the cost of hospital plus medical care during the periods of disastrous illness that require hospital care. We are now in a position to calculate on an actuarial basis. In order to make this plan a success, that fee must be divided between the hospitals and the medical men.

If the available fee is to be divided, then the part that goes to hospitals in the city of New York, at any rate, would be considerably less than the actual cost of caring for such patients in first-class voluntary hospitals. It then is necessary to introduce in some way, either directly or indirectly, a contributed sum over and above that which is paid into the plan by the proposed insured person himself.

Where to Get the Money

How is that supplementary money to be obtained? Is there any reasonable ground for supposing that the tens of thousands of individuals who contribute toward voluntary hospitals today will increase their contributions sufficiently to bear this cost? The supposition is questionable. Yet the cost must be met.

I can see no reason why an honest, earnest and continuous appeal should not be made to generous-minded well-to-do individuals in the city to contribute toward such a service. If it is legitimate, if it is humane; if it is effective to contribute the whole cost of hospital care to those who need to be supported to that extent it would be equally generous, more farsighted and perfectly consistent and proper for the donor class to contribute in part toward the support of dues-paying members of Class C and thus to remove them from the temptation and need of seeking 100 per cent charitable relief.

It is not inconceivable, although without American precedent, that the taxpayers may interest themselves in this matter and that eventually subsidies may be provided out of the tax fund.

If, as we in New York assume, no man, woman or child is to be permitted to suffer from the lack of medical care because of poverty or slender means, surely it would be relatively advantageous to the taxpayers to pay part rather than the whole cost of hospital care of a group that cannot care for itself single-handed.

Patients Will Pay Part

Obviously, if the million persons we are considering are removed from the medically indigent class to the partially self-supporting class under a group hospitalization scheme, then at least \$7,000,000 will be provided by the sick themselves and this \$7,000,000 is part and parcel of the \$35,000,000 which taxpayers are today contributing toward the care of the sick poor in the city of New York.

The interest of doctors in this matter is considerable. I have suggested that contributions toward the consummation of such a plan might be made by voluntary donors. I have suggested that taxpayers would actually profit by contributing a share. I hope that medical men will contribute also. I can see no justification, if a system of this sort is set up, for demanding that the services of the medical profession be contributed on a wholly gratuitous basis.

Medical fees should be paid. The fees will have to be pared down to meet the requirements of this special intermediate class.

If assistance is obtained from the voluntary contributors of funds, I believe that the plan would be equally successful in obtaining the cooperation of the medical profession in the form of substantially reduced fees. The scheme would be profitable to the medical profession because most of the patients in the group of which I speak are paying no medical fees at all when they are admitted to hospitals today.

Voluntary Hospitals Would Benefit

As a somewhat troubled hospital commissioner commanding nearly 20,000 hospital beds today, needing a great many more and feeling pressure upon the free city hospital services increase month by month and almost hour by hour, I will admit that a load of responsibility and anxiety would be removed from my mind if such a plan could be put through within a reasonable space of time.

It would shift from a large public hospital organization to voluntary hospitals a part of the almost impossible load that the public hospitals are today called upon to bear. That shift would engender a feeling of independence and self-respect in the minds of these persons thus freed from the unhappy state of medical indigence. They would be transferred from huge public hospitals to smaller voluntary hospitals where it is possible to conduct services more humanely. They would enter the voluntary hospitals as private or semiprivate patients and not as public charges and their spirits would rise accordingly.

Most of the physicians in this country are eager to see many features of medical practice preserved as they exist today. I respectfully submit that one way of maintaining medical practice is to develop such a plan as this.

I would like to see a large segment of medical practice now belonging to public or state medical service transferred back to private hands. The government has, of course, its proper function in caring for the indigent. But when government

agencies dealing with individuals, performing service of a highly individual kind as medical service, reach a certain point in their development, they become unwieldy and unmanageable. I am one of those who are wrestling with the problem of managing satisfactorily a huge public service today.

When we made our first approaches to the medical profession in New York and asked for its sanction of a group hospitalization plan without medical service, there were many physicians who were reluctant even to go so far. But after careful analysis they saw that what was proposed would be a service to the sick, a service to the hospitals, a service to the community and a service to the members of the medical profession themselves. And so it has proved.

In making this further appeal for their cooperation on a wider plane, I do so with the complete confidence that if the medical profession will join hands with the unselfish voluntary hospitals of the city, this plan can be put through and made a success.

We are in a fair way to accomplish this. Already the first approaches have been made and a joint committee exists today which is studying this problem from every angle in the interest of the city. Nothing has touched me so much as the unselfish spirit of the spokesmen of organized medicine, the feeling and understanding they have displayed.

The organization of such a service is inevitable. If it is too long delayed through inaction and indifference on the part of the voluntary hospitals, the contributing members of the community, those interested in welfare movements and the medical profession itself, it is possible that profit-making agencies seeking selfish advantages may take the initiative in this movement. The right and duty of taking the initiative belong to the medical profession, to the social workers, to the supporters and trustees of the voluntary hospitals.

I ask those who have to do with the development of group hospitalization to charge themselves with responsibility for seeing that the

service is eventually extended in two ways: (1) by adding medical service to hospital service in the plans that now exist, in a manner consistent with medical ethics and having the sanction of the medical profession, and (2) by establishing in appropriate ways a ward service plan including both hospital and medical service

in every substantial community in the country.

All of those who are eager to see private medical practice and voluntary effort in the field of organized medical service preserved and extended owe it to themselves and to their principles to throw themselves heartily into this movement.

"Secretary to the President"

EDWARD L. BERNAYS

IN ORDER to make sure that the news and human interest values inherent in the hospital are consistently reflected to all those mediums that may be interested, an additional worker should be engaged with some such title as "secretary to the president," whose duty it will be to serve as a publicity secretary or publicity assistant, at a reasonable salary, in accordance with the qualifications and experience of such an employee. A worker of this quality should carry out her duties under the executive direction of the president of the hospital, the committee on public relations of the board of trustees and the administration of the hospital.

These duties may be summed up as follows:

1. To keep in touch with such of the various departments of the hospital as may be considered sources of news, for instance, the social service department, the ladies' auxiliary, the occupational therapy department and the children's wards, with the object of obtaining material suitable for news or feature stories.

2. To read the newspapers and publications relating to social welfare and hospital work for the purpose of: (a) clipping anything that may be of interest to the hospital and (b) studying the trend of the news and making tie-ups that may be helpful to the hospital.

3. To compile lists of persons and groups that may be helpful to the hospital, such as lawyers, trust companies and banks (in connection with wills and bequests) and persons of wealth and of philanthropic point of view.

4. To assist in the preparation of the printed material of the hospital, such as (a) letters to groups; (b) occasional leaflets to bring out specific points that the hospital desires to emphasize to the public, and (c) the annual report from the standpoints of attractive and readable arrangement and setup of the material and of suitable news stories.

5. In addition to writing such copy and stories as may be assigned through the administration and the public relations committee, this worker should endeavor to make publicity suggestions based on her contacts with the departments and study of the background of the hospital. These ideas can then be considered by the administration and the public relations committee.

6. The publicity assistant should bear in mind the possibility of pictorial expression of the ideas and aims of the hospital through adequate photographs. In this connection it might be well to investigate the possibilities of acquiring a new stock of photographs of human interest phases of the hospital done in the modern technic. This should be helpful in giving added strength to the printed material of the hospital, including the annual reports.

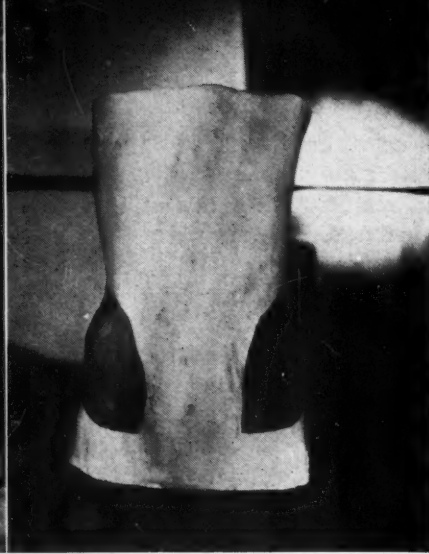
Hospitals have the best of reasons for impressing the public, and particularly the contributing public, with their humanitarian deeds. The method outlined above should be adopted as an investment that is bound to bring handsome returns. Quite apart from financial reasons, hospitals owe the community an adequate report of their work.



3. Removing the Shell



4. Kiln Drying



5. Spotted With Leather



2. Recasting the Model



1. Making the Shell

A Hospital Makes

Pictorial Report From Brace-making Shop of the Gillette State Hospital for Crippled Children at St. Paul, Minn.

1. The first step in making a brace is the preparation of the plaster cast shell. This is done by a house doctor and must be approved by a staff doctor. It is time consuming and is a tiring occupation for the patient, who in this case is supported by straps under the arms and chin.

Last year this shop turned out 56 canvas corsets, 92 leather jackets, 14 Taylor braces, 487 leg braces, 27 arm supports, 107 splints for support, 17 walking stirrups, Whitman arches, head tractions and leather arches and 578 new frames and appliances. In addition, 850 frames, appliances and pieces of apparatus were repaired or adjusted and 1441 shoes were built up and adjusted in accordance with physicians' orders.

2. After the shell has been approved by the staff physician, it is delivered to the brace shop where a model is cast. Last year the shop used 6400 pounds of plaster of paris, which costs about \$1.20 per hundred pounds, and 400 pounds of Hydrocal, a quick-setting plaster which costs about \$4 per hundredweight.

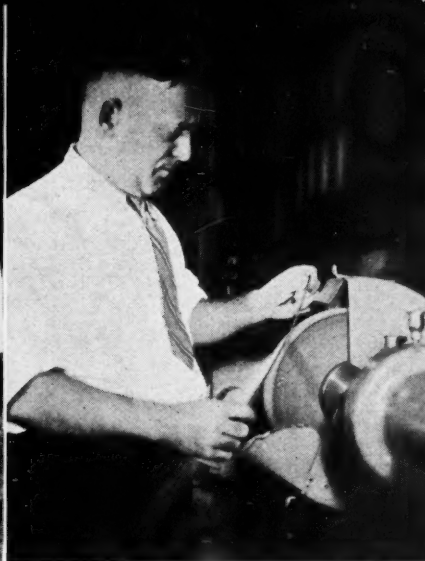
In all \$3265 was spent for materials last year and \$5425 for salaries. The equipment, machinery and tools in the department are worth about \$6000. The shop ceiling is soundproofed and there is a dust collecting system. These two features alone cost \$1500.

3. The shell is taken off the model and corrections are made to procure the right therapeutic effect. A leather corset for an adult costs about \$65; for a small child, \$45.

4. After the shell is removed the model is dried in a kiln at



6. Leather Molding



7. Steel Grinding



8. Sewing the Jacket

Its Own Braces

160° F. temperature for as long as four days. When suitably dry, the cast is taken out, filed and sandpapered.

5. After drying, the model is spotted and made ready for molding the leather. Some braces may be completed in twenty-four hours. Those that require recasting and kiln drying of plaster and leather may take as long as two weeks.

6. Before the leather is molded over the model it is soaked in lukewarm water to make it soft and pliable. Three types of leather are used: first-grade russet strap leather, which is cowhide, for the main body of the brace; pearl gray horsehide for linings, and chrome leather for covering the joints. After the leather is molded on, the model is put back into the kiln for about eighteen hours. It is then removed from the kiln and the brace is taken off the model and sent back to be tried on the patient by the doctor. It is then trimmed to the proper size and again put on the model.

7. It is now time to grind the steel supports. For this purpose spring steel, toe calk, a high grade of steel and drill rods are used. Drill rods are an exceptionally hard steel, which lasts longer than ordinary steel.

8. After the steel has been ground and polished it is riveted to the leather. Then it goes to the leather worker, who puts in the lining, sews it up and inserts eyelets for lacing. Arthur W. Palm, the brace-maker in charge of the Gillette shop, demonstrates on a completed brace how the lining is sewed in.

9. The concluding operation requires that the brace be again put on the model and perforated.

10. The final picture shows the patient wearing the finished jacket. Orthopedic braces of the modern type were first used 90 years ago. Pioneers in this work were Doctor Hessing of Germany, Dr. Arthur Steindler, Dr. Charles Fayette Taylor, Dr. Royal Whitman, Dr. Joel E. Goldthwait and Hugh Owen Thomas, the last named of England.

The braceshop visited is one of the particular joys of Elizabeth McGregor, superintendent of Gillette State Hospital.



9. Perforating



10. The Finished Jacket

Shifting to an Eight-

MARY ELLEN

THE amendment to the local law of New York City, reducing the working hours of employes in the municipal hospitals, on March 31, 1937, circumscribed the Department of Hospitals by decreeing that no worker can work more than six days in seven, nor more than eight hours out of twenty-four; the hours to be consecutive, with no reduction in compensation and to become effective on July 1, 1937.

This topic can be treated only in a general way, as each of the several institutions has made adjustments to meet its individual needs. Do not infer that all these problems are solved; some time will elapse before complete adjustment is achieved.

The inauguration of the eight-hour day for workers in the Department of Hospitals fell roughly into the following divisions:

1. An estimate of the needs in personnel (nurses for patient care and supervision, subsidiary workers and others), equipment (lockers and dressing facilities) and services (food, laundry, health service and medical care).

2. Preparation for installation (obtaining personnel, preparation of persons in the institutions and preparation of newcomers, rearrangement of routines to shift peak load periods, reorganization of time schedules and assignment of duties).

3. Actual installation.

4. Treatment of problems evolving from the institution of the eight-hour day.

Several methods were considered in computing the needs of additional nursing personnel. One method considered was the computation of weekly schedules, *e.g.* the reduction of the 55-hour week to 48 by supplying seven hours per nurse. However, the most satisfactory formula, in order to ensure against loss of potential services to patients, was the computation in minutes, plus "coverage." This formula consisted of supplying the difference (in minutes) for each nurse between her potential work time under the eight-hour day and her potential work time under the

longer hours of duty, plus "coverage."

To arrive at the potential work time of the nurse under the eight-hour day we deducted from the year ninety-three days (this figure is comprised of 28 vacation days, 11 illness days, 12 half holidays and 48 days (1 per week), leaving 272 days of eight hours each (480 minutes) or 130,560 minutes potential work time per nurse per year. Total minutes spread over the 365 days equals 360 minutes per day, the average potential service per graduate. A similar formula was used in estimating students' time. Therefore, in estimating the requirements in nurse time, we supplied the difference between 463 (our previous basis for estimating budgetary needs) and 360, or 103 minutes per nurse plus "coverage."

We were constantly aware that supplying actual minutes of service would not guarantee maintenance of existing standards of patient care. We recognized that small units were less flexible and more costly than large; that in small units it is more difficult to arrange relief for meals and emergencies. Therefore, it was necessary to make a plan for the coverage of each unit.

Part-Time Workers Called In

A major problem during this preliminary period was obtaining workers to prepare and serve the evening meal to patients. As it was impossible to arrange for the service of three meals within an eight-hour period, part-time positions were created for institutions located in vicinities in which such help might be available. Duties were combined in full-time positions for institutions unable to secure part-time workers. This position is especially useful when large numbers of patients are discharged in the late afternoon and there is a need for workers to clean beds and make preparations for new admissions. In

one institution, part-time positions were created especially for milk laboratory service.

The preliminary survey revealed a need for the following personnel: 37 supervisors, 1253 nurses for bedside care, 349 attendants, 461 full-time hospital helpers, 546 part-time hospital helpers, 31 full-time cooks, 6 part-time cooks, 64 ambulance enginemen, 1 elevator operator, 11 anesthetists, 2 technicians, 37 dietitians and 1 watchman at a total cost of \$2,595,095.

The increase in food costs amounted to \$250,000 and an estimate of such items as laundry and cleaning supplies, linen, lockers, stools, uniforms for waiters and other help, advertising and postage amounted to \$32,000.

Locker Rooms Needed

The increase in number of nurses on a nonmaintenance basis (because of inadequate housing accommodations) increased the need for locker and dressing room facilities. A locker was requested for each new position and rooms formerly used as rest rooms by nurses during their hours off duty were converted into locker rooms. Inadequacy of laundry facilities was met by providing for each position granted in the eight-hour day appropriation a laundry allowance of \$5 per month.

The problem of inadequate dining room facilities for the personnel was met by spreading the meal hour and arranging three sittings. Some institutions issue meal tickets. The dining room personnel has been a real problem. A reallocation of work has been difficult, as the workers cannot be assigned to the preparation of vegetables and other foods or to work in other departments of the hospital during quiet periods of the day.

To obtain the necessary personnel appeared to be an unsurmountable task. Looking backward we wonder at our apprehension. The subsidiary

Hour Nursing Day

MANLEY, R.N.

workers and hospitals helpers were supplied largely from lists furnished by the Emergency Relief Bureau.

For the subsidiary worker a plan was evolved whereby applicants for the positions might be assigned to the several institutions for an orientation period prior to July 1. To prepare personnel in the individual institutions to effect this orientation of new workers, a four-day institute for the supervisory members was held by the division of nursing.

Nationwide Call for Nurses

A sufficient number of nurses were enrolled through a nationwide campaign of advertising in newspapers, professional journals, contact with over 1400 accredited schools of nursing and their alumnae associations. The cooperation of the New York State and National Reemployment Services, professional and other groups was enlisted.

Whereas prior to July 1, 1937, the qualification requirement of the Department of Hospitals for nurses was New York registration, an adjustment became necessary to permit the employment of nurses registered in any state.

Prior to the institution of the eight-hour day, the Department of Hospitals carried between 200 and 300 vacancies in nurse positions. Now the number of vacancies is negligible, about 64 spread over the 27 institutions.

The sudden influx of large numbers of nurses with varying backgrounds made an intensive staff education program imperative. Our staff education program embraces conferences, lectures, demonstrations, excursions and discussions. Special orientation plans were worked out. New nurses were assigned to shifts when the most supervision was available. New members of the staff were interspersed over many units with older workers.

To stabilize the service, it was necessary to prepare our own workers for the innovation before July 1. We postponed vacations, shifted schedules and reassigned duties and responsibilities.

A major concern was the arrangement of time schedules to cover the twenty-four hours adequately to have the necessary personnel on duty during peak load periods, considering also the needs of the workers. When schedules concentrated workers during certain hours, routines were shifted, *e.g.* the meal hour, temperature taking and ward teaching programs. Morning conferences were moved to early afternoon when many nurses were on duty.

There are nurses who prefer the day and night shift to the afternoon shift (2:30 p.m. to 11 p.m. or 3:30 p.m. to midnight). A rotating schedule has been devised, sometimes changing daily (especially in instances in which nurses wish to pursue college work or for other reasons to be free certain evenings each week). Some administrators believe this is a good plan as it keeps the nurses alert to the daytime activities, such as the doctors' rounds. In some hospitals the rotation of shifts is on a monthly or bimonthly basis. It has been found to be a good plan to allow the nurses to make their own decisions regarding rotation. It precludes difficulties and makes the plan much more effective.

Taking Care of Holidays

When we investigated the tendency of workers to report on duty late and leave early, we found some discrepancy between our schedules and transportation facilities. Some buses do not run after midnight. This makes it necessary to have afternoon workers off duty before midnight.

If transportation could not be adjusted (in some instances, it was

possible to adjust bus and ferry schedules), the shifts of duty were adapted accordingly.

Our budget appropriations allow personnel four hours off duty for holidays. If these are given as half the working period on the holiday, it means that some workers report on and off duty during the early hours of the morning. This contingency is met by combining two holidays and therefore giving one whole day off duty.

Breaking the day into three divisions, instead of two, necessitates writing three reports instead of two and emphasizes the importance of overlapping schedules sufficiently to facilitate the complete shifting of responsibility at the close of each period.

Additional Supervision Needed

Additional supervision has been needed for afternoon and night shifts because of the telescoping of each individual's day. This has had to be provided according to unit needs.

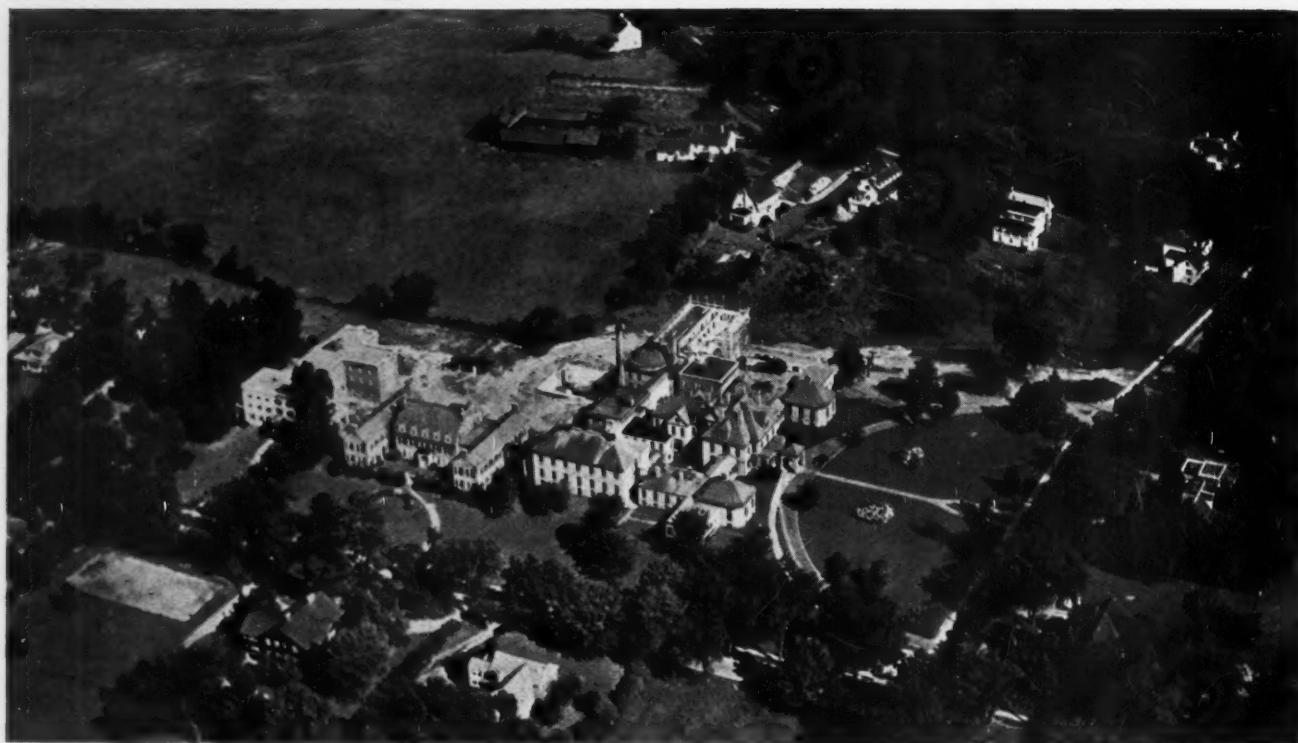
It has simplified timekeeping and pay roll records to have complete work shifts come within the calendar day from midnight to midnight.

We already are contemplating the effect that institution of the eight-hour day in voluntary hospitals will have on the Department of Hospitals. All things being equal, many nurses prefer to work in voluntary institutions.

In most instances executives report enthusiasm among the staffs because of the eight-hour day. The turnover in personnel has been too high, but we expect this to be minimized as time gives us greater opportunity for selection.

We anticipate that the reduced hours of duty will have significant outcomes in improved care to patients through a reduced amount of illness, less fatigue, improved morale and general stabilization of staff.

Groups in our institutions are now studying means of helping the nurse weave into her daily plan of patient care those little courtesies that make nursing a true art.



Health Center in the Hills

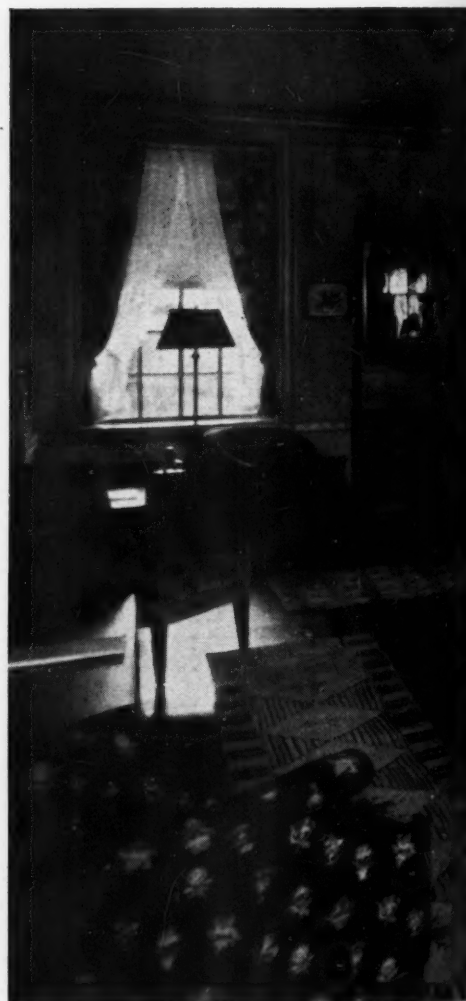
RAYMOND P. SLOAN

THE rolling countryside of New Hampshire is not exactly the spot where one would deliberately seek a medical center. Yet in the town of Hanover, just across the Connecticut River from Vermont, the unusual is found. Mary Hitchcock Memorial Hospital is its name, an appellation given it forty-eight years ago when it first was organized as a cottage hospital.

Its group of rapidly spreading buildings nestled among the hills is not to be confused with those of Dartmouth College, although there is a definite tie-up between the two. This relationship, in fact, is just one link of a chain that carries beyond the immediate area into the state, forming a headquarters for education and research as well as for medical and surgical treatment and care. Its aims are two: (1) the hospital must care for all patients irrespective of their financial abilities; (2) it must provide adequate medical and nursing service to as great a territory as demands it.

How it is accomplishing these aims is revealed in studying not only the hospital alone, but those public health projects with which it is aligned, centering upon the work of a group of men of such caliber that the poorest person can obtain high-class medical care at minimum expense. But first it is necessary to turn back some forty-eight years.

Hanover first became acquainted with hospitalization in 1890 when a cottage hospital known as Mary Hitchcock Memorial Hospital was organized. For thirty-seven years it served the community. In 1927 the then small staff began considering the possibilities of a group clinic permitting of enlargement by the acquisition of well-trained men—men who ordinarily would not be interested in the limited possibilities of development under the individual staff system. This marked the turning point in the hospital plan. What more logical place to carry out their ideas than the hospital? They were sufficiently farsighted to see the op-



portunities available to them through this very direct relationship; the hospital, in turn, saw its staff problems minimized. This was the origin of Hanover's medical center.

The plan formulated at that time exists today, but on a much more extensive scale. There are now sixteen doctors in the group who pay the hospital a nominal rental for office space and who supply their own nurses and office assistants. Under the terms of the arrangement they take care of all free work and ward cases for which no professional fees can be charged. In addition, there are seven interns serving eighteen or twenty-four months.

Mary Hitchcock today is the fountain head from which emanate various activities of a public health nature. The hospital plant has a bed capacity of 162; it is headquarters, as already has been pointed out, for

education and research as well as for providing medical treatment and care.

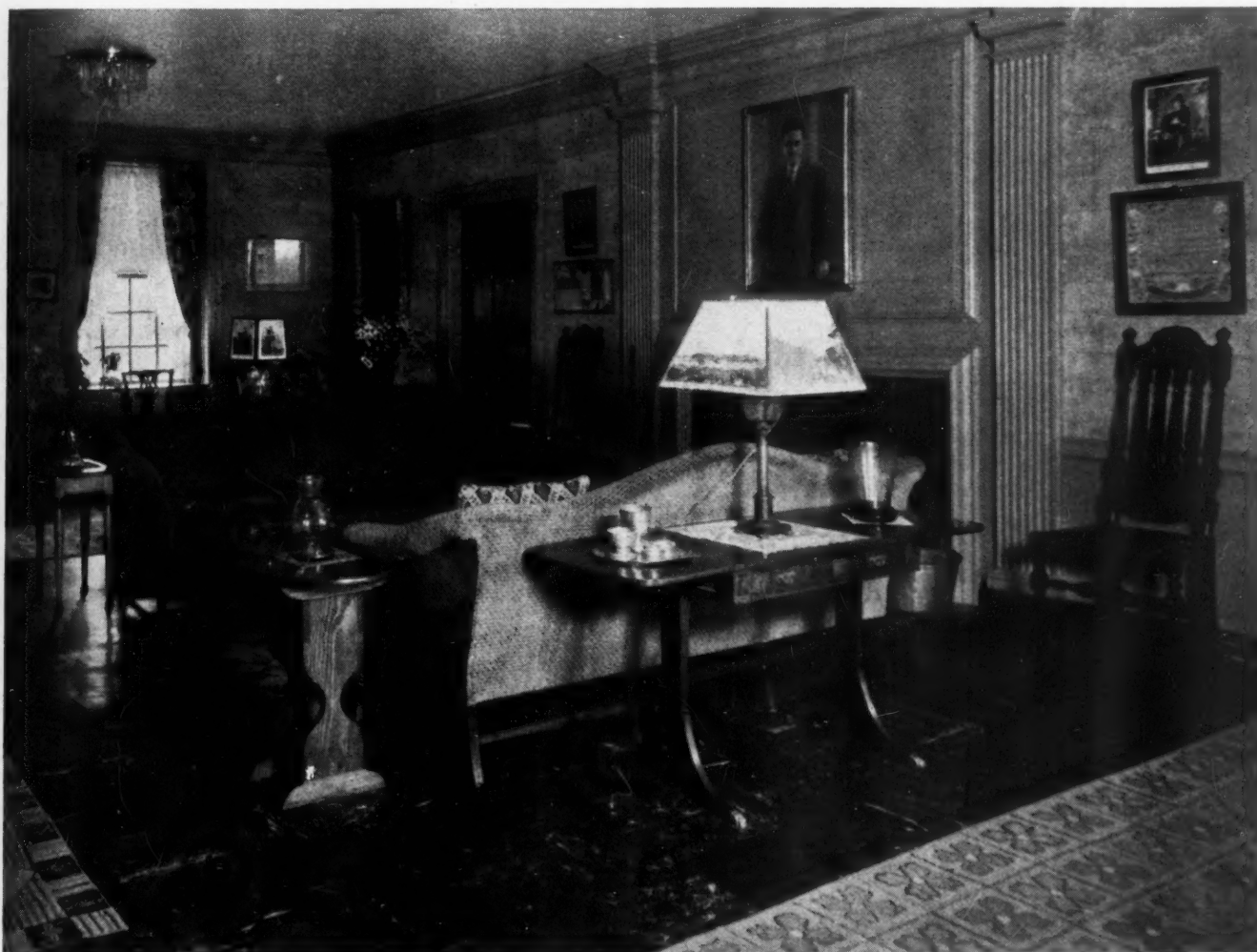
First, there is the clinic, conducted by the sixteen doctors. These men also serve on the teaching staff of the medical school of Dartmouth College, which is adjacent to the hospital property. Their entire professional work centers at the hospital and they, with nine others, comprise the entire professional staff. These nine are not members of the clinic, however, but are on the faculty of the school. They serve as consultants to the hospital for which they receive in some instances modest financial remuneration. To repeat, one of the aims of the institution is to pick men of such caliber that the poorest person can obtain high-class medical and surgical care at minimum expense.

Another hospital project tied in directly with the college and com-

munity is the Dartmouth College health service, which provides for the care of students requiring out-patient care and hospitalization. This activity centers in Dick Hall's House, adjoining the main hospital. In this pleasant country home hospital facilities are available to thirty-four boys. This number can be increased to sixty-two by turning over rooms and areas now assigned to other purposes, such as visiting parents' rooms and solariums.

Here home atmosphere prevails and the hospital aspect is minimized. Walls are decorated with attractive Colonial papers. Early American furniture, quaint chintzes, the gleam of shining brass and the sparkle of clear crystal complete the picture, with a smoldering log fire in the spacious lounge on cold days to add the final touch. The same general interior treatment has been applied to the recently completed nurses' home and will be carried throughout the hospital as renovations are made. The college operated health service reimburses the hospital for the cost of maintenance. Special nurses are

Center of the new Dartmouth College health service for undergraduates inaugurated a year ago last fall is Dick Hall's House. A view of the spacious living room is shown below. The painting over the mantel is of Dick Hall, in whose memory the house was given by his parents. An airplane view of the health center is shown at the top of the preceding page.



also allocated to Dick Hall's House.

The third project is the medical school, which is tied in with the hospital through the professional staff.

The eye institute—a fourth division of hospital interest—is conducted under college supervision. This comprises two definite programs, research and clinical work. The research is carried on by the col-

only to Hanover but to an increasing area in New Hampshire and Vermont. Only 13 per cent of the patients admitted to the hospital, in fact, come from Hanover itself. Eighty-three per cent are sent in by physicians from all parts of the two states and points even more distant.

To appreciate the attitude of the hospital toward the needy sick it

"What do they do when they're off duty?" he inquired.

His question was answered as accurately as possible.

"I want to give them a good time," he replied. Again he produced a check, which he also made out for \$10,000 with the stipulation that it be used expressly for educational and recreational facilities for the nurses.

An isolated instance, to be sure. More typical of the attitude of the immediate countryside toward the hospital is the fact that Hanover with a population of 3500, exclusive of the student body, raised \$140,000 last year for the building fund. The interlacing of various local interests in the hospital and the community health program assures generous public support.

Every effort is being made throughout the state to fight off any form of paternalistic government. There is little "relief" as it is practiced today and charity is accepted only as a last resort.

This is best illustrated by a typical incident. Donald Smith, superintendent, received a call not so long ago from the chairman of selectmen of a neighboring town. The purpose of the visit was to inquire how much the town owed the hospital. From the total sum of uncollectible bills he paid \$1700 in full. On others he paid 33 1/3 per cent. In all he turned over \$3400 to the hospital.

Of an endowment totaling \$548,000, the sum of \$354,000 is set up for endowed beds. No public supported individual is permitted to use these accommodations. They are solely for those individuals who can just get by.

It was discovered that certain towns, because of small population or lack of needy people, were not and could not possibly use the income accruing to them from the share of the endowment designated to their use. Others were running far behind. So a different arrangement was effected. Today the total amount of endowment for free beds amounts to \$354,000, with an additional income of \$2000 from unrestricted endowments. This sum is allocated to the various towns based on their distance from the hospital, population and the number of poor people. The hospital is doing be-



In nine alcove living rooms like this in the new nurses' home student nurses at Mary Hitchcock Memorial Hospital may chat, read or listen to the radio.

lege as a branch of the medical school; the operative clinical work is done in the hospital.

Finally, there is the nurses' training school with all modern facilities for nursing education. Approximately sixty-nine girls are in training at this time, and fourteen will be graduated this spring.

As part of its expansion and modernization program the hospital has opened a new nurses' home with accommodations for forty-eight girls including recreation room, sun roof and commodious lounges. The new home adjoins the old residence, which is still in use, and is attractively furnished with maple furniture, set off by color on the walls and in the upholstery fabrics.

The organization reviewed thus far presents an interlocking chain in which the hospital and those identified with it, administrator and trustees with the professional groups and college heads, work together with but one thought: community health service. This service, too, applies not

becomes necessary to know something of the predominating characteristics of the people it serves. Conservative and unassuming, their thrift affords the administrator many a surprise.

Several years ago a farmer wearing rough boots strode into the superintendent's office to ask how much a free bed would cost. He was referred to the admitting office across the hall. In a minute he returned with the same question. Again he was urged to consult the admitting officer. "But I don't want to lie in one. I want to buy one," he explained.

He was invited to sit down while the amazed superintendent presented the facts. Then calmly he drew from his pocket a check which he proceeded to make out to the hospital in the amount of \$10,000.

Five or six years later this man was a patient in the hospital. As he was leaving he expressed the opinion that the nurses should have more opportunities for play.

tween \$16,000 and \$17,000 of free bed work annually.

As further evidence of the hospital's service within the area, the sum of \$39,000 was charged off last year's income of \$188,000. Of this amount \$24,800 was for strict charity, and uncollected bills were \$14,200. Collections are carefully followed up both by mail and by personal call. A collector travels in the interests of the hospital, working on commission. It is understood that his methods must in no way reflect hardship but rather become part of the educational program to impress the people that, despite the hospital's endowment, they share some responsibility in its operation.

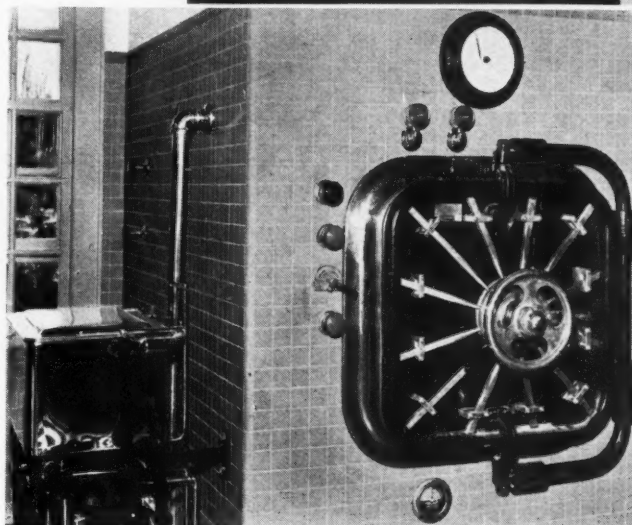
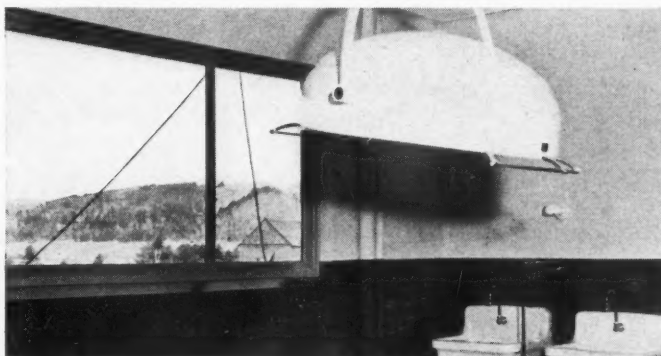
Again to emphasize the fact that the aim is 100 per cent service, any person in restricted circumstances can be admitted to the hospital at the \$3 ward rate, which is 60 per cent of the per diem cost and with 50 per cent off the regular charges for x-ray, laboratory and similar extras.

There are some 150 members of the hospital corporation from which a group of twelve trustees is selected to serve a term of three years. Five of these comprise the executive committee. The trustees meet once every three months; the executive committee, every month. Conspicuously absent are the usual special committees—inspection, house, nursing and the like. The administrator is wholly responsible for the conduct of the hospital.

When it first became apparent that an expansion program would be necessary, a building fund committee was established. So successful was this that upon the completion of the campaign, recommendations were made for the permanent establishment of a committee on public relations to be responsible for conserving and developing the benefits derived from the campaign. This was deemed essential because of the growth of demands upon the hospital and the large and increasing volume of organized medical services in general. Last year the hospital operated at 92 per cent of capacity.

This committee today constitutes the prime interest of the lay group and is responsible for the organization of such subcommittees as the committee on building funds and

A corner of one of the two major operating rooms showing the excellent lighting arrangements. This floor also contains three other minor operating rooms.



Another corner, this time in the nurses' work room, showing two sterilizers. The room is done in gray-green ceramic tile.

endowment; committee on trusts and funds; the auxiliary, which contains funds for current needs and other objects; the committee on publicity and education, which is responsible for the production and distribution of all written publicity, and the speakers' bureau, which is responsible for a program of spreading information regarding the hospital through the spoken word. The committee on public relations with the chairmen of these subcommittees comprise a council of public relations "through which information shall be disseminated, the work of the hospital interpreted, interest aroused and funds obtained."

Evidences of the work accomplished originally by the building fund committee are apparent to every visitor. There is the new nurses' home already described. Even before that, two ward additions were completed. As this is being written a new four-floor wing is about to be opened, which will house the maternity and pediatrics departments, a complete suite of operating rooms and a floor of laboratories and

classrooms. Adjoining it is the new laundry and heating plant with facilities for present and future needs.

Some \$300,000 had to be provided for these very necessary improvements, and an additional sum will be required to see the program completed successfully. This becomes the function of the public relations council through its committee on building funds and endowments as well as its other subcommittees. Because of the contacts maintained through the college alumni, the interest in the hospital becomes nationwide.

The hospital is fortunate in having an extremely active auxiliary, comprising some 2200 members. Each year its members stage three major events, which in 1937 produced approximately \$6000. In the fall a day is set apart when foodstuffs and cash are donated to the hospital.

Then in March comes the North Country Fair. This is held for two days in the college gymnasium, during which time the whole community adopts high-pressure sales tactics for the benefit of the hospital. There is

dancing, an automobile and other objects are given away and gayly decorated booths provide ample opportunities to buy and help the hospital. This event last year netted \$3500.

Last summer for the first time these industrious workers sponsored the Interstate Horse Show, a one-day event. Among the entrants were boys and girls from the neighboring camps who staged exhibits and vied with one another for honors. So much interest was aroused that it will undoubtedly become an annual event.

Hanover, because of its location, is the center of a large summer colony. The hospital has taken advantage of this and through its speakers' bureau and a special committee deliberately seeks the support of the many boys' and girls' camps scattered all over the north country. This committee works with camp directors and counselors in allocating certain field days on which swimming and riding events and similar exhibitions take place for the benefit of the hospital. Last year the camps turned over about \$1500.

This is the health center in the New Hampshire hills as we see it today. Before leaving it let us take a brief glimpse into its future plans.

What is that business-like looking building rising several stories high on the hospital property? A modern doctors' office building, as we might have known, with examination rooms, waiting rooms and all facilities for keeping records, bookkeeping and other professional routine. It is the home of the Hitchcock Clinic.

And what about that mysterious looking building with the curiously shaped roof? A new eye institute, of course, in which all manner of optical research takes place.

Alongside the nurses' home, which, by the way, looks considerably larger, is another building that engages our interest—a residence hall for graduate nurses in which they can rent attractive accommodations at nominal prices.

As for the hospital itself—a 350-bed institution perhaps, who can tell? To quote from a recent report of the hospital's president, Max A. Norton, "We may well imagine here an institution of greater value not only to our own region but to the general

hospital field. Certainly it is desirable to see in our work a standard of practice and alertness to progress that may be a guide to better medical service and improved health standards for rural areas in general."

It requires little imagination to

evoke such a picture. It is already there in pattern at least, outlined indelibly on the New Hampshire landscape, a pattern that the hospital field may well adopt for its manifold benefits to the health of town and state.

Occupancy at New Peak in 1937

THE rate of occupancy in general hospitals reached a new high of 70 per cent of capacity during 1937, it has been revealed by the annual census of hospitals just completed by the council on medical education and hospitals of the American Medical Association. This figure was 67.4 per cent in 1936.

Interpreted according to the population, one person in fourteen became a hospital bed patient during 1937. The average length of stay in general hospitals was 12.6 days. Persons entered hospitals at the rate of one every 3.4 seconds.

Total patient days in all hospitals was 344,719,140, a gain of 12,202,284 over the preceding year. The patient days in general hospitals numbered 105,222,200, or 30.5 per cent of the total. The 4245 general hospitals admitted 8,349,773 patients, or 90.5 per cent of the total admissions.

New hospitals in addition to the 6128 already registered include 100 hospitals opened but whose registration is pending, seventy under construction and 179 planned.

Reports were received from 97.6 per cent of the hospitals, representing 99.4 per cent of the total capacity.

Because of the increasing number of small general hospitals in rural districts and the reclassification of certain related types of institutions that have been developing in the direction of general hospital service, general hospitals made a marked increase in number, capacity and occupancy figures.

States in which less than 60 per cent of the beds in general hospitals were occupied have a low ratio of hospital beds to population. Those states which showed an average occupancy rate above 75 per cent are densely populated and liberally provided with hospital facilities.

Eighty-six state mental hospitals reported an average census more than 15 per cent in excess of rated capacity and seven exceeded their capacity by more than 50 per cent. The reports cover 273 mental institutions, seven more than last year.

While nineteen states give statistical evidence of improvement in the facilities of state mental hospitals and several states have kept the ratio of overcrowding to the hospital capacity constant, fifteen states show an increasing percentage of overcrowding over 1936. The number of commitments to mental hospitals from the date of the hospital census to the end of the year 1937 indicates a steady increase in patients admitted that outweighs any attempt to extend facilities or to return patients to the community.

During 1937 seven mental hospitals reported new buildings or additions to the old, caring for 4320 patients. Fourteen states have made appropriations and plans for twenty hospitals to be constructed in 1938.

Seven states are planning for future adequate service. A progressive building program is under way in Rhode Island that will add 3000 beds, sufficient to care for all patients until 1941 or 1942. Pennsylvania is relying upon completion of an extensive building campaign to cut its waiting list. Overcrowding in two Illinois hospitals will be remedied by transfers to a modern unit of 6300 beds. California plans for a future capacity of 6000 beds in one of its hospitals. A small state levy collected over a period of ten years will benefit a Nebraska institution.

The average occupancy rate for all hospitals for the year was 84 per cent; the average daily census showed 16 per cent of all hospital beds idle.

400,000 More Beds

EACH year finds the hospital filling a place of increasing importance in the maintenance of the nation's health. At one time, only the person near death went to a hospital; today, the sick go to receive care and to be cured; tomorrow, well persons will seek the hospital for the prevention of illness and disability.

The technology of modern health service requires increasing use of the clinic and out-patient department. The facilities must be adequate for the care of the bed patient, the ambulatory sick person, the patient in the early stages of disease and the person in need of preventive care.

The increasing importance of the hospital in our national health services is the result of a variety of factors. In urban centers, home care of the sick is increasingly difficult in the crowded dwellings of the majority of the population. In rural areas, physicians can increase their efficiency and effectiveness tremendously if a hospital is available to furnish diagnostic and consultation facilities. Here the hospital serves a larger purpose than the treatment of its in-patients who constitute a small fraction of all the sick; it becomes the center for health services of the community and influences the quality of care in the doctor's office and in the patient's home.

Furthermore, the pattern of illness is changing as the proportion of older persons in the population increases. The illnesses of adult life—cancer, diabetes, heart and circulatory diseases, kidney diseases—are not subject to the mass methods of environmental control; they require attention to the individual through the services of physician, dentist, nurse and technician. With the increase in complexity of diagnostic and therapeutic procedures, care can often be given best in a hospital in which modern facilities for diagnosis and treatment, which the private physician cannot maintain for himself, are available.

This is the hospital section of the report of the technical committee on medical care of the Interdepartmental Committee of Coordinate Health and Welfare Activities appointed by President Roosevelt on Oct. 27, 1936

Although the hospital facilities of some communities, especially of some large cities, exceed current effective demand for service, existing institutions are grossly inadequate to meet the needs of the population in many parts of the country. Such inadequacies are especially important and severe in rural and in economically underprivileged areas.

Enlargement of hospital facilities is needed in many areas where there are some hospitals; construction of new institutions is required in many regions where none have been built. Without such institutions, well equipped and well staffed, many of the important services which twentieth century medicine offers to the public are impossible of attainment. Furthermore, there is a growing need for other local facilities equipped to serve as centers for diagnostic and preventive services, where organized health agencies may operate in close correlation with medical and related practitioners.

Professional standards of adequacy indicate a need for general hospital facilities in the ratio of 4.6 beds per thousand persons, nervous and mental hospital facilities in the ratio of 5.6 beds per thousand persons and tuberculosis hospital facilities in the ratio of two beds per annual death from this disease. In this country today, more than two-thirds of the states fall below these standards in general hospital facilities, nine-tenths are below the standard for mental hospitals and three-fourths of the states fall below the standard for tuberculosis hospitals. For general hospitals, even a minimum standard of two beds per

thousand persons for areas (mostly rural) which are 50 miles beyond a large hospital center would require substantial additions to existing facilities.

A total of 31,000,000 people now live in areas with less than two general hospital beds per thousand persons. Nearly 1300 (42 per cent) of the counties in the United States have no registered general hospitals. Being largely rural or sparsely settled, these counties include only 15 per cent of the population. Nevertheless, this means that there are 18,000,000 persons who are living in counties with no local hospital facilities. Special surveys would be required to determine which of these counties are adequately served by hospitals in adjacent counties and which need additional local facilities.

Looking Ahead Ten Years

Capital investment in hospital construction diminished from a figure of \$200,000,000 annually in the period 1923-28 to about \$50,000,000 in the period of 1932-36.*

A large part of the relatively limited construction in the latter period was the result of the P.W.A. program. The stimulation of new construction is imperative because of

*This statement, while undoubtedly accurate, is somewhat misleading since it does not show the changes that have taken place in hospital construction activity. Figures in the office of The MODERN HOSPITAL show expenditures for hospital construction (including modernization and extension of existing structures as well as new hospitals) as follows: 1934, \$39,038,000; 1935, \$41,445,000; 1936, \$95,659,000, and 1937, \$103,492,000. At the time this is written (March 3, 1938) the current year is well ahead of the same period of 1937. While total expenditures are increasing, P.W.A. assistance is decreasing.

this resulting accumulated deficit.

Today the United States has about 1,100,000 beds in general, special, mental and tuberculosis hospitals. According to the minimum professional standards of good care, about 1,500,000 beds will be needed by the end of the next decade. This means a deficiency of about 400,000 beds. Measures to fill this need would include the construction of at least 500 hospitals of from 30 to 60-bed capacity in rural and sparsely settled regions that have inadequate hospital facilities at present.

The amount of chronic disease and the need and economy of adequate care have been demonstrated by the National Health Survey. Some chronic patients require diagnostic and treatment services equivalent to those of an acute hospital case; others need only skilled nursing or custodial care after their condition has been diagnosed. The large number of beds needed for chronic patients of both types should usually be built in association with general hospitals.

In addition, health and diagnostic centers are greatly needed in rural

areas where they may serve as centers for the local health department staff; visiting nurse services, maternal and child welfare staff, for basic laboratory and other diagnostic services; for local physicians, and for emergency beds.

It may be conservatively estimated that about 500 such diagnostic centers might properly and usefully be built in areas which are without local hospitals but, being adjacent to areas which have hospitals, can have the needs of their people and their physicians met by these centers.

A Word for the Intern

RUSSELL H. OPPENHEIMER, M.D.

ALL business and professional relationships imply mutual helpfulness and benefit. It is this interdependence that calls these relationships into being. Benefits may be expressed in many forms: in money, in commodities, in service, in the pleasure of accomplishment, in mutual advancement.

The practicing physician is entitled to and should receive compensation in money as well as in personal satisfaction. By the same token, the remuneration of interns must be based on an evaluation of the benefits derived by the hospital and the reward properly due to the intern.

Tradition frequently warps our judgment and stifles action. It is traditional that the intern should serve without compensation in money. This tradition developed when interns had little in the way of professional knowledge or ability to offer the hospital and when the hospital assumed it had much to offer the intern. Observation of the duties and responsibilities of interns in the present day hospital are proof that previous ideas of the intern-hospital relationship no longer apply.

Today the graduate in medicine who enters the hospital as an intern has been thoroughly trained, both in theory and in practice. He is capable of taking an accurate history, of making a competent physical examination and of forming a logical impres-

sion concerning the patient's illness. This careful work is often of much help to the practitioner who has charge of the patient, even though he himself has made such examinations. The observations of an intern may be of considerable importance. In this day of hospital inspection and standardization, the work of the house staff has much to do with the impression formed by the examiners.

The intern is closely concerned with the treatment and care of the patient. He is in the hospital all day, observes the progress of the patient at frequent intervals, reports to the attending physician the important changes in the condition of the patient and commonly carries out routine or emergency measures. Patients no longer regard him as "just an intern." They think of him as a doctor of sufficient accomplishment that he may be helpful to them both physically and mentally.

In a well-organized hospital the capable intern assists the attending physician and, in view of the present methods of treatment, he does much to save the time and energy of the visiting physician. A capable intern staff is as important to the modern hospital as any other part of its organization. This present position of the intern applies equally to the charity and private hospitals.

On the other side of the hospital-intern relationship, in the close patient-intern-visiting physician relationship now prevalent, the intern gains much from his contact with patients and from his observation of the practitioner. He has the opportunity of gaining the maturity of thought and judgment necessary to apply in practice the information he brought with him to the hospital and gained during his service there.

In its final analysis the question is: Does the intern or the hospital receive more from the association? The answer seems to be that the hospital is more likely to be indebted to the intern. For that reason it is appropriate that the intern receive an allowance in addition to the usual room, board and laundry supplied him.

As in the practice of medicine, no accurate monetary evaluation can be made upon the work of the intern. Would it not be simpler, therefore, to establish small monthly stipends that will enable him, after his many years of expensive education, to meet the little necessities, in this way relieving him of some of the expense of his continued education and at the same time giving him the encouragement that will come from the recognition of his professional worth?

Supplies System for Small Hospital

EARL G. ROWLEY

WHILE the years 1936 and 1937 have shown improved economic conditions so far as Citizens General Hospital, New Kensington, Pa., is concerned, and while we are at present filled to 111 per cent of our 100-bed capacity, rising food and supply costs have not permitted us to relax a whit from the stern economy measures enforced or to look tolerantly upon wastes and leaks. One move made has been the installation of an unusual system for handling, distributing and checking supplies.

We might have swung completely over to a central supplies system, had we the required space. But we did not have it, and we will not have it until such time as we can finance a new building. Nevertheless, the conditions we faced were such as to compel action of some sort and so we attempted a compromise which has resulted in a system that may be unique. At any rate, it is different, and we have been entirely pleased with the result.

At the time the system was put into effect, it was difficult to control wastes or leaks, no matter how conscientious the personnel and it was not easy to keep an accurate check on where and when supplies were needed, or to maintain an open in-

ventory so that we could buy advantageously.

One floor might have an excess of certain supplies, while another was short. We could not keep the man in charge of stores on duty at all hours, yet emergency calls for supplies were likely to come at any hour. The system of requisition slips, then in use, gave us a literal check on the

Once each week the supervising nurse in each department checks all supplies on hand to learn what must be ordered for the next week. She writes these on the store sheet, which goes to the director of nurses for checking and then to the stores man to be filled. Supplies are arranged in the store-room in the order listed on the sheet so that no time is lost as the man moves the basket of supplies from bin to bin.

issuance of supplies, but it failed to indicate how we were using supplies in comparison with the month before and the month before that.

We then decided to try a system which would do away with requisitions and would substitute for them a large store sheet on which were spread in the open, therefore easily seen and compared, the amounts



called for, week by week, over a period of three months. The three months' period required as large a sheet as could be conveniently employed. It is a logical unit in view of the fact that the hospital's accounting system lends itself to a quarterly basis, conforming in this respect to others receiving state aid.

Four main hospital floors or departments regularly call for supplies

in their routine. These are the obstetric department, on the first floor; the section housing male patients, on the second floor; the section caring for women patients, on the third floor, and the surgical department, on the fourth floor. In addition, there were the drug room, the kitchen, housekeeping, maintenance and the laboratory. All of these except the laboratory, which is rather small, use the large sheet, but each sheet differs in the supply items listed, depending upon the nature of its needs. The laboratory sheet is a small one, itemizing only those supplies that it requires.

The procedure, simply phrased, is this: The supervising nurse, say, on the women's floor, makes a check each Thursday forenoon for all supplies on hand. She knows then what amounts must be ordered to run her department for the coming week. These she sets down in the proper column on the large sheet, on which are typed the correct names of all supplies likely to be called for. As she does this, it is only a moment's work to look back over the requisitions of the past weeks to be certain that her latest orders are in line.

When she has completed her order, she sends the sheet to the director of nurses, who also checks it, and then it goes to the stores man to be filled. He has so arranged his supplies that they conform to the way the items are listed, and it is a simple matter for him to move the basket along from bin to bin and from shelf to shelf, filling the order rapidly and avoiding the necessity of darting here, there and everywhere for each item, however small it may be in size or quantity. The amount of time this operation saves is astonishing. When he has finished, he marks each item ordered with a red checkmark, and the department head, when she receives the allotment, indicates with a blue checkmark that each has been accepted.

Much the same procedure is followed by the other departments. The sheet filled in by the obstetric department, naturally, will contain items not on any other. That allotted to the dietitian will have on it all supplies used routinely by that department, exclusive of foodstuffs. The whole system has worked so

smoothly that it rarely is necessary for the sheets to be referred to the superintendent. Each department head realizes that the responsibility is up to him or her.

Before the system was installed, there always were difficulties. Our stores department might be low on some one item, but hidden away in some cupboard upstairs would be an excess supply that was deteriorating and would eventually result in a loss. Calls for emergency supplies would come at the most unseasonable hours and it was harder and harder to keep an accurate check on our supplies. With the system of requisition slips in use, no one could tell accurately whether the order should

THIRD FLOOR

PRINTING

- Bedside Notes
- Clinical Charts
- Daily Reports
- Diet Sheets
- Door Cards
- Ear, Nose and Throat
- Extra Charges Books
- Eye Records
- House Correspondence
- Laboratory Records
- Laboratory Requisitions
- Linen Requisitions
- Medicine Sheets
- Narcotic Requisitions
- Patients' Clothes Books
- Personal History—Physical Examination
- Progress Records
- Record of Narcotics
- Repair Requisitions
- Report Anesthesia
- Requisitions, Kitchen Supplies
- Treatment Record
- Valuable Envelopes
- X-Ray Laboratory

OFFICE SUPPLIES

- Blotters, Desk
- Blotters, Hand
- Ink, Blue
- Ink, Red
- Labels, Large
- Labels, Small
- Paper Clips
- Pen Points
- Pencils
- Rubber Bands
- Scratch Pads, Large
- Scratch Pads, Small
- Tags, White
- Tags, Morgue

SURGICAL DRESSINGS

- Adhesive, ½ inch
- Adhesive, 1 inch

be filled at face value or what amounts had been used previously.

In ordering supplies, the use of a standard nomenclature has eliminated many vexing situations. For instance, take such a simple requirement as clinical charts; one department will call them clinical charts and another, temperature charts.

When we had decided to do away entirely with the loosely handled method of distributing supplies, we created a new post—that of manager of stores—and trained a person to handle the work of purchasing and distributing all supplies. He can now buy with full knowledge of what the future requirements are likely to be. Once a month he makes rounds and checks inventory. He knows exactly what has been used and by his perpetual inventory can tell where the hospital stands on supplies at any time.

For two years this system has been in effect and we believe it has paid dividends in savings to the extent of at least \$1200 a year. From one leak alone, that of paying express and postal charges for small rush orders, an important saving has appeared through the new system. Our inventory will run, on the average, about \$5000, and our annual expenditures for routine supplies, aside from food and fuel, approximate 15 per cent of our total operating cost, which is around \$150,000, including pay roll. So, while not the major part of our hospital expense, a saving of \$100 a month is by no means unimportant to us.

Such a system might not work to advantage in a very large hospital, but for a small hospital, which lacks the necessary room for a complete central purchasing system, it holds promise of smoother operating procedure, lower costs and improved cooperation between department heads and administration.

When we installed the system, we held a meeting of all department heads and explained its workings and its purpose. They fell in with the idea immediately and have helped to keep it working. The townspeople, including our board and women's auxiliary, know of it, and they have shown a greater interest in the struggles of the hospital to keep going.

City Hospital Problems

A. C. BACHMEYER, M.D.

LIKE other modern institutions of similar character the city hospital's functions are fourfold: (1) the care of the sick and injured (in this instance, primarily the indigent); (2) the education of the public in matters pertaining to health and general welfare; (3) the training of young men and women in the practice of medicine and allied fields, and (4) the advancement of science through study and investigation.

The modern hospital, voluntary or governmental, has these functions to perform, and if those in authority fail to visualize them and to carry on all the activities implied in the fullest and broadest sense, the institution fails in its mission to society.

Municipal hospitals are usually established in acknowledgment of the community's obligation to provide for those who are economically unable to bear the costs of medical care. In furnishing aid for those who derive a direct benefit from the services of the hospital, the community also makes provision for a better standard of health for all of its citizens and thus derives an indirect benefit from the institution.

Two of Hospital's Tasks

The immediate care of the sick and injured, the expenditure of every effort toward the restoration of physical and mental health, the removal of causes of repeated and recurring illnesses, the functional, as well as the physical rehabilitation of the patient, are the primary purposes of the institution. I do not mean to imply that it is the hospital that actually performs these activities but that it is its rôle to furnish the facilities and ancillary personnel that the medical profession may accomplish these ends.

This, however, is only part of its task. The second function, that of education, is of equal importance and, in the last analysis, of greater value to society.

All hospitals should serve as educational institutions. There should

be a definite program looking to the instruction of the patient as to the nature and meaning of wholesome habits and of proper conditions of living, first, in relation to his immediate needs and, second, as they are related to his general health and happiness. We undertake extensive programs of health education for the public, but often neglect those who are most interested because of their own immediate experiences. Every effort should be made to instruct the patients, their relatives and friends in matters pertaining to the cause and prevention of illness.

Teaching the Patient

In recent years we have seen the establishment of programs for the instruction of the tuberculous patient, and also of classes for those who are the victims of diabetes, but there are many other conditions in which similar instruction would be helpful and in which little or nothing has been done. The patients who leave our hospitals should be missionaries of good health to the general public.

Ordinarily mention of the educational functions of the hospital refers only to medical and nursing education. Affiliation with a university serves to guarantee a high standard of professional service.

In every instance in which there are such affiliations, a far better type of medical care is found than where such associations do not exist. There need never be any fear that patients will suffer in a teaching hospital because of the ministrations of medical students. The teachers in our medical colleges today are selected because of their competence as physicians and surgeons, as well as for their pedagogic ability. The student cannot be properly instructed unless he can observe the best type of professional service.

The students of today are the physicians of tomorrow. Therefore, if

in addition to the immediate care of the sick, the hospital's facilities can be utilized in the training of future physicians, nurses and other allied professional personnel, future generations will derive a direct benefit and the institution's influence for good will extend far into the years ahead.

Investigation and research in the biological sciences are frequently costly and one might justly question whether the city should engage in such activities. The large number of patients in the city hospital and the great diversity of their illnesses afford many opportunities for investigation at comparatively little expense. While the hospital is primarily a service institution, no opportunity to contribute to knowledge of the cause, prevention and care of disease should be overlooked that can be undertaken within the available funds. Success in research leading to advances in medical science pays huge dividends in human welfare and happiness.

Old and Inadequate Equipment

It is true that medical care is expensive in terms of immediate financial cost. Inadequate and incompetent medical care, however, is vastly more expensive in financial cost as well as in terms of human suffering and disability. In recent years municipal hospitals have had huge burdens of service imposed upon them. The demands have in most instances exceeded the budgetary appropriations and the standard of service has suffered. The city cannot expect efficient service if it does not supply the funds necessary to provide such service.

The years of the depression have left their mark in many places. In the interest of service to the patient, physical facilities have often been neglected. The city hospital has not escaped. Such practices cannot be continued indefinitely. Increased funds are essential and must be pro-

vided in order that we may avoid irreparable damage not only to structure but to the health of the community as well.

Municipal hospitals need not vie with voluntary institutions, designed mainly for patients who can pay part or all of the cost of their care, in such matters as room accommodations, furniture, linen, china, silver and similar appurtenances. The splendid furnishings of some of our hospitals are not essential for that class of patients for whom the city hospital is intended. We have learned, however, that drab, monotone decorations cost as much as pleasing colors and that with a little forethought and careful planning an attractive environment can be provided at no greater cost. We have also learned that pleasant surroundings react favorably upon the patient and have a distinct therapeutic value. Municipal charity hospitals should no longer be the somber, dismal institutions of former years.

While certain differences in furnishings and equipment may be accepted, there should be no difference in the adequacy or quality of the professional service between the government and the voluntary hospital. Whether the patient is "private" or "free" he should receive competent and efficient medical and nursing care. It is not, however, because of inadequacy of diagnostic or therapeutic equipment that municipal hospitals are so often criticized, but because of other factors that so largely influence the standard of their service.

When Petty Politics Interferes

The iniquities of petty civil politics are too often the disturbing factor that interferes with the efficient operation of the municipal hospital. Surely in an institution designed to serve sick and suffering humanity there is no place for the chicanery of self-seeking politicians.

In many of the municipal and county hospitals of the country the traditional party policy, "to the victor belongs the spoils," is in evidence to the great detriment of the service. Appointments to high and low positions are made, not upon the basis of merit and fitness for the position, but for political reasons. Even when

by chance, or by premeditated plan, a capable administrator is placed at the head of an institution, his subordinates are often selected for him by those in authority in the political party or the positions are parceled out among the various ward and precinct captains whose prerogative it is to fill vacancies that may occur. The administrator is so hedged about by restrictions that he cannot conduct the institution with any semblance of efficiency.

Political Appointees

Political appointees seldom hold their positions longer than the term of the elected officers. Although the same party may be continued in power through successive elections, each change in elected officers is followed by changes in appointive positions.

It is this practice that is primarily responsible for the faults and deficiencies encountered in municipal and county hospitals. It is remarkable that the service is as good as it is for little can be expected when political and personal interests and financial compensation alone are of major concern and the qualification of the personnel for their tasks is merely incidental.

When this system involves only the nonprofessional personnel of the hospital the situation is intolerable, but when it includes the physicians, nurses and other professional personnel, as it does in a number of instances, the resulting conditions beggar description.

Civil service commissions have been established in many communities in an endeavor to overcome this difficulty. When commissions are free from political influence, when civic-minded, able men can serve upon these boards and when the commission conducts its work in an honest, intelligent and efficient manner, vast improvements to the situation have been effected. In a number of instances, however, such commissions have served merely as a screen behind which the iniquitous practices have been carried on the same as of old.

Some communities have sought to solve the difficulty by placing their hospitals under boards of management, the members of which are so

appointed as to make the boards independent of any political control. In most instances of this type the results have been highly satisfactory. Many cities, however, find it impossible to adopt this plan because of legal restrictions.

In some instances, advisory boards have been organized. In cases in which these are composed of independent, civic-minded citizens, who take their work seriously and who serve to keep the institution free from political domination and to keep the public fully acquainted with the institution, they provide a safeguard of the public interests.

In a few communities the municipal hospital and the public health service have been traditionally non-political activities, and there has been no political interference in their conduct. The electorate in such communities would be quick to show its resentment of political meddling.

Keeping the Public Informed

Many citizens have direct contact with the hospital. Patients, their relatives and friends have a direct interest in the institution. Physicians of the staff, nurses and all other members of the personnel are, or should be, thoroughly conversant with the affairs of the hospital. Many civic, fraternal and church organizations have from time to time indicated a willingness to participate in one way or another in hospital service. Particular groups, such as women's auxiliaries, the Junior League and Red Cross volunteers have contributed in no small measure to the effectiveness of hospital services. The press always has shown a desire to support worthy civic projects and has on many an occasion saved an institution from the hands of despoilers. The newest devices of radio and motion pictures are readily at hand.

All of these agencies should be utilized in informing the public concerning the functions and service of the institution. A sound and comprehensive program of public relations should be formulated. Where the personal contacts are so numerous and intimate as in the municipal hospital, there should be little difficulty in creating and maintaining an informed, understanding electorate.

Kitchen Ills and Cures

A Consultant's Close Range View

THE dietary department is distinctive to hospitals since each hospital has individual kitchen requirements that differ in some respects from those of every other hospital. Because of this specialized service the same pattern cannot be applied to the dietary department that is used for other kitchens doing large quantity cooking. Yet how many know these differences well enough to enable them to adapt plans and specifications to meet specific requirements? The answer is found in the large number of kitchens that do not give the best returns for money expended.

Designing a dietary department calls for the combined knowledge and experience of the architect, the superintendent, the engineer who should be familiar with kitchen needs (often the house engineer is the best as he also knows existing conditions), the dietitian and the chef. Not all dietitians and chefs, however, are prepared to pass on plans. If those on the hospital staff are not qualified to do so, a consulting dietitian may be employed, usually for a fee that is only a fraction of the sum she will save in buying equipment of the type and amount adapted to the designated purpose.

Permanent Handicaps

Errors in planning do not merely inflict temporary inconvenience. They are a constant handicap to workers and a drain on the budget year after year. A high priced appliance loses much of its value when placed where it cannot be used to the best advantage or where it does not facilitate the work as a whole.

A pleasant sight is an attractive dietary department generously supplied with modern equipment. When made a convenient workshop, it becomes a source of pride for any hospital. Unfortunately, the latter does not always follow. Conversely, a methodically arranged department with a good organization

may give a maximum of service and be a comfortable place in which to work, yet not be attractive to the uninitiated.

Considerable redesigning and equipping are under way at present and both call for as much forethought and planning as new construction. Sometimes there are construction difficulties in old buildings that cannot be overcome, but in most cases they can be greatly lessened by judicious changes and rearrangements.

Making Cleanliness Easy

Among the more common faults is the absence of any sink or running water adjacent to the cook's table. During the rush of meal preparation the cook wastes much time and energy if he must walk some distance to a sink. The temptation is to become careless about cleaning soup materials, vegetables for seasoning and similar things which he does himself and to neglect proper washing of utensils between usings. Soiled towels and hands naturally follow. One lapse in cleanliness naturally engenders others. Then, too, heavy kettles of water must be carried back and forth many times daily.

Uncovered food and open doors of cupboards and refrigerators are so common in some kitchens that they no longer attract the attention of the employees. If food is to be kept in good condition, it cannot be exposed for long to the heat and dust of the kitchen and the contaminating elements in the air. Sometimes this carelessness is due to an insufficient number of cupboards and storage closets to accommodate supplies and utensils frequently used, such as flour, sugar, spices, strainers and pans, or to a lack of refrigeration space. Sanitary laws cannot be observed without adequate storage for staple supplies as well as perish-

able foods. All containers on shelves, as well as barrels and boxes, should be tightly covered. This practice and ample refrigeration facilities help to reduce waste and spoilage.

Vegetable preparation rooms, rooms in which salads and desserts are concocted and, occasionally, receiving rooms, frequently are not located in main traveled paths. Deliveries to or from these rooms usually require a truck or cart. Unless the room is large enough for the cart to be taken inside, it obstructs the passage, and this may occur many times in a busy forenoon. Work is retarded and temptation offered to every person passing. It is so easy to pick up a banana, apple, tomato, bunch of grapes or similar small thing, yet these items mount to a large total in a week and many times larger in a year. Irregular eating drains heavily on the budget and every precaution should be taken to prevent it. Another leak of this nature exists when no definite place is provided for serving prescribed diets to the personnel. Eating in the floor pantries or any haphazard place is hard to control. It should never be permitted to begin.

Too Much Detail Hinders

Probably one of the most common extravagances in hospitals is to employ a dietitian at a salary of from \$125 to \$150 or more per month, in order that the food service may benefit from her professional training and a systematic, hygienic régime be established, and then to impose upon her detail work, such as copying orders or devising special dishes, that might well be done by an employe at \$16 to \$18 per week.

Insufficient workers, inferior products, poor cooking, lack of adequate tools and, most of all, lack of responsible management are in no sense an economy. The wise super-

intendent looks for these very leaks.

It is possible to point to many neglects in the details of dietary layout that have resulted in major difficulties. Yet many of these could have been easily avoided in the original planning.

In one instance, four windows in one outside wall and two doors in an opposite outside wall made a pleasant, well-ventilated, comfortable kitchen until the wall with all of the windows was partitioned off for a vegetable room in which two persons worked about half of each day, and a silver burnisher section where one person worked twice a week. In consequence, the kitchen staff was forced to work in a darkened, poorly ventilated room all day.

Costly Errors in Planning

A second example is that of a room for preparation of salads, desserts and other cold foods which was located next to the room where trays were set up complete with dishes and all cold foods. A large refrigerator between the adjoining rooms opened into both of them so that the finished cold dishes could be placed on large trays and put into the refrigerator from one side, and, at serving time, removed from the other side and the dishes quickly transferred to the patients' trays. A good plan, unquestionably, but in construction the opening into the tray room was made too small to accommodate trays. Removing the individual dishes separately took more time than carrying the full trays through the door and into the other room. The result was an unnecessary amount of time and labor three times a day, not to mention an opening into the refrigerator that was practically useless.

In another institution the food for private patients was good, extravagantly so. Not only was the food itself more expensive than justified, but the portions were larger than necessary and there were too many extras between meals, totaling more than anyone should eat, particularly for those confined indoors.

Food for the other departments was of good quality but not satisfactory to the dietitian or to the consumers, primarily because the time of all dietitians and nurses in the

dietary department and some of the best kitchen workers was devoted to the preparation and serving of food for private patients. A vegetable preparation room with mechanical devices was a part of the main kitchen with two men employed to do that type of work. Yet all fruits and vegetables for private patients were prepared in the diet kitchen by student dietitians and student nurses. Naturally, they were slow and not expert at this work, which could be done better and more quickly in the vegetable room, and they were getting little training in dietetics. The diet kitchen was in disorder most of the day and this confusion was reflected in the work of everyone in it.

A dishwashing room and serving pantry opened off the corridor leading to the nurses' dining room. The door had been removed for convenience and for ventilation, and the view afforded the nurses in passing made them critical of the food before it was served. Establishing order in the serving pantry and placing a screen before the doorway did much to change the nurses' attitude.

Locating a Working Center

Picture, if you will, a first-class layout for kitchen purposes, completely spoiled through lack of understanding of the service. This was a large room with a row of windows along one side which would have provided good light for the cooking unit had it been placed in the middle of the room at right angles to the windowed wall. This location would have established a working center which would have minimized travel through the room. If the bakery, salad room, rooms for tray setting and dishwashing were grouped in a compact unit at one side of the cooking unit, this would permit the trays to be set up on the food carts with all cold foods in readiness to be taken in a direct route past the cooking unit for the hot foods and to the elevators, with only one trip through the kitchen in getting the meal out and another when the dishes returned for washing.

Instead, the cooking unit was placed parallel to the wall with the steamers and stockpots on the side next to the windows and the ranges on the opposite side, making it nec-

essary for the cooks to work by artificial light. Also, the preparation and dishwashing rooms were so scattered that carts and delivery trucks had to cross the room from four to six times each meal. The number of times the workers were obliged to cross the room has never been estimated. They were continually getting into one another's way, interfering with the cooks, keeping the kitchen cluttered and consuming no end of time. Reason given for the arrangement is that the stockpots are unsightly and should be back of the range out of view.

How to Cut Down Waste

Looking still further, we find a kitchen and allied rooms dirty, insanitary and greatly in need of renovation, the equipment old and inadequate and a pressing need of more and better refrigeration. Every improvement that should have been made had been held up for a long time because a new building was contemplated. In keeping with the physical condition, food was not properly cared for and waste was appalling, particularly of milk, cream, butter and eggs. A dietitian was engaged for six months on trial. She had the whole place cleaned up at once, some repairs made, largely by the house mechanics, and a junk room converted into an excellent refrigerator. The morale of the department greatly improved. In a short time the student nurses' attitude toward their dietetic training changed, the doctors became interested in their dietary orders and the food service to both patients and personnel was the subject of favorable discussion inside and out of the hospital.

All of this change was made at comparatively little expense. The first three months of her supervision the dietitian saved a sum equivalent to her six months' salary on all these items, with considerable additional saving elsewhere. The new building was begun ten years later.

A sixth example reveals a good arrangement of rooms, plenty of light, ventilation and work space but equipment badly in need of repair and a lax organization. The superintendent, realizing that the department was not giving all that

might be expected of it, sought to find the cause. The local equipment house was asked to submit an estimate on new equipment needed, but the cost submitted proved to be prohibitive at the time. Later, an analysis of the department was made by an expert in hospital kitchens. As a result, new appliances were bought, some repairs made, chiefly by the house mechanics, and improvements effected in working conditions. The organization was tightened and brought up to date and service generally improved.

Under the direction of one familiar with hospital kitchen technic, conferences were held with the dietitians, engineer, carpenter and local equipment salesmen. The change from an unsatisfactory department to a satisfactory one was made at comparatively small cost. The benefits over a long period of time cannot be estimated in money value.

One badly planned physical layout presented a handicap with which little could be done. Rooms and equipment were in a sad state because a new building was in the offing and funds were limited. Duties were faithfully performed but, for lack of help, the dietitian spent most of her time in routine tasks instead of in supervision and planning that would have been of greater value to the hospital. A spirit of lethargy prevailed in the organization because they had been "doing the best they could" for so long.

With the help of an expert adviser readjustments were made and badly needed equipment was ordered with suggestions for other appliances to be bought later. A part-time secretary for the dietitian released this executive for the things that she alone could do. The staff was inspired to new zeal, the board of directors' interest was aroused to the extent of buying not only the equipment recommended at once but also that suggested for future purchase. A new system is now established by which the hospital will profit for many years, possibly until the new building materializes.

A dietary department was established in a new building with beautiful rooms throughout and ample modern equipment. It was planned for central service, all trays to be

sent from the main kitchen to the floor kitchens. Yet in this kitchen there was only one small icebox for the cook's use and the nearest refrigerator outside of the kitchen was approximately half a city block distant. The service was to private patients only and the amount of traveling to and from the refrigerator would have necessitated extra employees if the food had been served as it was meant to be. Even then it was not always possible.

There was no cupboard or other provision for small supplies and utensils, which the cook uses almost constantly at every meal and likes to keep under his own supervision. The dietitian's office was surrounded by the dishwashing room, the kitchen and the elevators. All of her planning, conversations and any creative work had to be accomplished in the midst of this din.

Once I was invited to visit "a perfect kitchen, perfectly equipped," in a large public hospital. The perfect

kitchen was found to have whole batteries of steam cookers, upright ovens, stockpots and other expensive appliances that had never been used and never would be, for the house was then operating at full capacity. A casual estimate of the cost of this surplus machinery approximated between \$6000 and \$8000. There it stands to be cleaned week after week, year after year.

One error after another might be cited, all of which might have been rectified had the original layout been studied by someone familiar with hospital food service. Fortunately, the superintendents in charge of the institutions referred to, most of them men nationally known in hospital circles, have realized that correcting faults in the dietary department is good business. Although easier and less expensive to prevent mistakes than to correct them, a remedy can generally be effected at an expenditure that eventually will prove to be an economy.

Automatic Corridor Lighting

AS MIRACULOUS as the progress across the sky of Helios, the Greek sun god, announcing the coming of day, is the photo-electric eye that controls the lights in the main-east-west corridor of the new building at Albany Hospital, Albany, N. Y.

As the rays of the morning sun grow brighter and the need for artificial illumination within the hospital decreases, the photo-electric cell operates automatically to shut off a whole line of corridor lights. As the rays of light outside decrease, the photo-electric cell turns them on again.

The magician who reveals this trick is the hospital's director, E. W. Jones, who points out the advantages of controlling the turning on and off of lights in main corridors and other places where it is important not to waste electricity, but where it is equally important to be sure that lights are on at certain levels of daylight in order to avoid accidents.

"Ours is a well-known commercial

and industrial installation and merely consists of the use of a photo-electric cell to turn lights on and off in accordance with the intensity of the outside rays of light," Mr. Jones explains. "As the rays of light increase the photo-electric cell automatically operates and shuts off a whole line of corridor lights. As the rays of light outside decrease the photo-electric cell automatically turns on the same string of lights.

"The apparatus itself cost \$36 and an additional \$12 to install, making a total cost of approximately \$48. It controls a string of twelve 200-watt bulbs. We estimate that the use of the electric eye saves approximately four hours per day. This multiplied by 2400 watts gives 9.6 kilowatt hours per day. Counting 3500 kilowatts per year, we have estimated our annual saving to be \$56.25.

"This saving, however, is of minor importance compared to the safety factor of being certain that dark corridors are lighted when they should be."

Morale in Mental Hospitals

J. ALLEN JACKSON, M.D.



MEMORIES of hospitals and hospital personnel extending over a period of twenty-eight years, ten spent in a large municipal hospital for mental diseases and eighteen in one of the outstanding state mental hospitals, bring visions of faithful department heads, trustees and fellow officers who really made the venture worth while. Without their complete cooperation and enthusiasm, efforts at promoting morale are doomed to failure.

Each hospital administrator knows the basic fundamentals of good hospital morale to be: (1) good wages; (2) good food; (3) good living quarters or, better still, living at home; (4) the best working hours and working conditions; (5) dynamic leadership; (6) stable but pleasing personalities in key positions; (7) discipline, and (8) a

The women nurses' home at the top, above, fits into the pleasingly landscaped grounds. Shown directly above is one of the fairways on the hospital golf course. Activities on the athletic field, right, may be watched from the veranda of one of the nurses' homes or from the grandstand.



square deal in handling human shortcomings, illness and distress.

Each administrator knows that this set-up is Utopian and can be only partially achieved.

In my experience the best plank in the platform is an adequate salary. As I look back over the years, the thing that most stabilized the personnel was money. Our present employees are not mercenary. Their reaction is due to the fact that low wages have been paid throughout the years. Rooms and maintenance have always been overvalued. Hospitals made a great mistake when, in the beginning, maintenance was provided for its employees, other than those necessary to protect the hospital. Many hard years would have been spent more happily if the employees had been paid good wages, allowed to mix with the outside



established. Then he may aggressively eliminate the unfit. By acquainting the employees with his justification for doing certain things, their support is obtained through understanding, kindness and consideration. Hospital personnel is made up of human beings who react to discipline tempered with kindness. They are conscious of the hospital's limitations. They will share your burdens with you if you are frank with them and promote their welfare. Promotion of good morale in a hospital is a joint enterprise of directors, management and employees.

The conditions responsible for the hospital's environment determine the type of policies formulated to promote good morale. Likewise, the methods and technique depend on

Patients and also hospital employees and their families may enjoy the library at the left. A part-time librarian is in charge. Below are views of the male nurses' home and of the tennis courts, which adjoin the hospital athletic field.

world and live in normal homes under normal conditions.

As to food, one cannot make such a generalization. I contend that ward employees and those in food departments who are engaged at meal hours should not be allowed cash for meals. Why tempt a hungry stomach and thus lower morale?

In addition to the basic fundamentals of good personnel relations, some less important personnel aids are strategic. Brief mention will be made of some of these.

Twenty-five years ago municipal institutions were far from ideal. In the one which I entered, politics played havoc with any attempt to promote decency. Salaries were small. Applications were kept on file, they were politically sponsored and included some rare specimens. Yet from this m  le was built up, over ten years, a fair morale, credit for which was due largely to reform administration, and the full confidence and support of those in power.

Today equally bad conditions prevail in many such institutions. Building morale in such an environment may be accomplished by attacking the environment, slowly and gently, until the administrator is securely



environment. The policies formulated and the methods and technique used in promoting morale in the state institution I have served during the last eighteen years differ from those of the preceding years, spent in a municipal hospital. The state institution was stabilized, and had been practically free from political interference. Its trustees had been almost continuously reappointed to office, and there had been only three superintendents in a period of forty-eight years. Better facilities were provided; there was a school of nursing; and the employees, taken as a whole had been long in the service. Thus the

There was no occasion for a gathering of employees except on commencement night and an occasional dance. The so-called Centre, which houses the business offices of the hospital, was used for this purpose. With an increase in personnel because of the hospital's growth, immediate attention had to be given to a social center. The solution to this problem was found to be a utilization of the amusement hall, which had been used only for patients' dances, class instruction, commencement and employees' dances.

A more serious problem was a satisfactory adjustment of wages,

These adjustments were quite satisfactory for a period of approximately fourteen to fifteen years.

A central library with books of fiction, poetry, history and travel was provided for patients as well as employees and their families.

A modern athletic field was laid out for the use of the patients and employees. The baseball team served to entertain the patients and to promote sports among hospital employees. Upon this nucleus we expanded these activities, and today our athletic field is one of the finest in central Pennsylvania, with a baseball diamond, running tracks, tennis courts, volley ball courts and space for softball games. A banquet is usually held in honor of the players at the close of the season, at which outstanding speakers are provided. In addition to the field, space in the basements of our two infirmary buildings was utilized to provide swimming pools for the use of patients and employees.

Likewise, arrangements are made for capping exercises for new students, breakfast for the graduating class, and a reception and dance for the graduates, their families and friends. It became necessary, as the years went on, to change somewhat the special dances which were held for employees on Halloween, New Year's and Easter, as it was found that the privilege of inviting two guests, for which cards were issued, was being used more by people outside of the hospital than by the employees themselves. Other types of entertainment were provided and dances are now held only at Easter and following the commencement exercises. Employees in the hospital are also permitted to attend the high class motion pictures that are provided for the patients biweekly, afternoons and evenings, insofar as seats are available. A little publication called the *Tattler*, published monthly, carries news items of interest to the hospital and to the employees.

In making up our program, we felt that some of our activities should be sufficiently inclusive to benefit the families of our married employees. They may participate as spectators at the baseball games and play tennis with some employee. To make closer contact with the families a personnel



Home for maids and laundry girls at the Danville State Hospital, Danville, Pa.

foundation had been laid for a good hospital morale and the first consideration seemed to be the care of the patients and the ultimate goal, the good name of the hospital.

The situation, therefore, confronting the new superintendent was to promote this morale and at the same time to institute constructive policies and to lay the foundation for serving the community, both from within and without the hospital. This required a long period during which a cordial relationship existed between the management and the personnel.

The welfare of the personnel demanded as much consideration as the care of the patients. For example, few modern facilities were provided for employee comforts and recreation, and those that were provided were rather restricted. There was no male nurses' home; the women nurses' home was overcrowded, and there was no home for other help.

which were very low during the war period. This problem was met with satisfaction to all parties concerned, and a standing committee was appointed to discuss with the superintendent any problems that might arise relating to personnel. In later years, a scale of wages allowing for increases within grade was approved by the state. Nothing acute arose on this matter until last year when the old problem revived because the scale had been abolished during the depression and minimum salaries disregarded in order to provide employment for as many people as possible. During the depression no salaries were reduced nor any employees dropped from the payroll.

The question of hours, food and quarters was adjusted by a shortening of the hours, by building a male nurses' home and a home for outside women employees, and by providing for additional dining room service.

worker, who devotes part time to the duties of librarian, was added to the staff. The personnel duties of this worker are to visit the homes of sick employees; to offer such service as the hospital might render, if requested; to provide a plant or some flowers in the sick room, and to stand by in the matter of automobile transportation in the event of death and funerals. We endeavor, during the winter months, to arrange our motion picture schedule so that the mothers and children are permitted to enjoy the best attractions of our motion picture schedule.

The policies, program and technique for the promotion of good hospital morale in the future must be varied. Any gesture on the part of the hospital in the matter of higher wages, good food, good quarters, shorter hours of work, vacation periods and sick leaves with pay will not be accepted with the same appreciation as formerly, when institutions had little to spend. The new generation, in the light of the social and economic doctrines that are being disseminated throughout the world, will expect the hospital to provide these as necessities. While we must regard these as the basis of a good morale, we must keep in mind new plans and new policies that will build up a good morale in the new groups.

First, we should all recognize that the good name of a hospital and the service that hospital is rendering to the patient and to the community now rest, more than ever before, upon the shoulders of three distinct units, the directors, the management and the personnel. In the past there has been a set-up for a close contact for the first two groups, and now there must be a close contact with the third group. This can be best accomplished by a committee representing the personnel as a whole, and by individual contact with the superintendent.

The old atmosphere, in which the superintendent and employees gathered in cheerful and harmonious contacts, no longer prevails. The unit is being broken up by virtue of the modern trend among employees to think in terms of economic security for their families, and their homes. Where they formerly lived in the institutions, they now seek a

more normal life—a life that has been made possible by means of good roads and good transportation. Just where and how they will spend their hours of recreation and diversion are beyond the control of the hospital, unless some public scandal arises, which merits immediate dismissal.

The conditions confronting us at the present time require the highest types of personalities, which can only be procured through adequate salary, commensurate with training.

Just what the large hospital may do in the future in promoting morale cannot be foretold. Some of the courtesies mentioned herein may be retained and extended. A social center, with medical, dental and social serv-

ices for the families of employees, athletic fields for the children, entertainments of various kinds and summer camps may be provided. In this direction we may follow the trend of large industrial organizations.

For the present we know that the most contented and loyal worker is he who is adequately paid; who works under the best working conditions as to environment, hours and vacations; who has a sense of security in his position, and who knows that his superior officers are capable, kind and just in their dealings with him. Perhaps the employee of the future, if he receives these considerations, would prefer to plan his own recreation in his own manner.

Eight-Hour Day in Canada

ADoption of the eight-hour day for private duty nurses in Canada has reduced unemployment to a minimum, the committee on nursing and nurse-training in Canadian hospitals has reported to the Canadian Hospital Council.

Although the reduction of unemployment has been a big factor, it has been placed in the background as other benefits derived from the experiment have been realized.

The public has accepted the shorter day in a whole-hearted manner. Patients are enthusiastic because (1) they benefit from more efficient service produced by the improved mental and physical fitness of the nurse; (2) the shorter day reduces the cost by providing special attention during the period of time most beneficial to the patient; (3) the reduced cost makes it possible for the patient to have added days of service, and (4) in some cases it eliminates the necessity to provide sleeping accommodations and reduces the meal inconvenience to a minimum.

Doctors appreciate the new schedule because it means greater efficiency in the nurse and provides the best for their patients. Keener observation and more intelligent execution of orders are notable. More consistent practical experience gained by nurses because of more frequent

employment is proving a valuable aid to doctors in that a greater number of nurses are kept in step with the latest developments in treatment and technical procedures.

In no locality where the compulsory eight-hour day was inaugurated has there been a return to a longer service. This factor is probably due to the favorable opinion of the private duty group. Hospital administrators have assisted the private duty nurses in their efforts to establish the eight-hour day and report no inconvenience to the hospital and the public.

The principle of the eight-hour day for student nurses has met with almost universal approval of nursing administrators throughout Canada, although it has not been generally adopted because of financial reasons. British Columbia has the eight-hour day in all its nursing schools.

In Alberta five of the eleven nursing schools have eight-hour duty.

In Saskatchewan the eight-hour day has been approved but has not been effective because of the lack of finances and the additional accommodation necessary for a larger staff.

Only three schools in Ontario have adopted the eight-hour day.

In Quebec the ten-hour night still prevails although several of the schools have a forty-eight-hour week.

WITH THE ROVING REPORTER

Hospital News by Radio

• Again the radio comes to the aid of the hospital in making the community conscious of the service it is rendering. But first it is necessary to visualize a picture of a community in South Dakota—Pierre, by name—to which people come for hospitalization from a radius as great as 150 miles. George Kienholz, secretary of the South Dakota State Hospital Association, describes the situation dramatically.

"Some of them live fifty miles and more from the railroad, ten miles from the nearest telephone and receive their mail once or twice a week. Winter roads are sometimes impassable for months except by team and sleigh or horseback. At such times their only contact with the outside world is through the radio. What the radio has to say each day is the main topic of conversation. When sickness comes the doctor cannot reach them any more easily than they can get the sick member of the family to town, and there is always the fear, even after the doctor does arrive, that he will advise hospitalization. So by whatever means with the help of their neighbors they can devise, they get that patient to town and often to the hospital.

"The patient progresses satisfactorily but, remember, the family is still isolated on the great prairie. Here is where radio proves a great boon. For several years a daily broadcast of the condition of all patients at St. Mary's Hospital who request it has been given three times each day—9 a. m., 12 noon and 5 p. m. These broadcasts are sponsored by the leading druggist in the city. The name of the doctor in charge is always withheld. Here are some typical reports:

"John Smith of Nowlin is feeling much better and does not want his folks to come unless he calls for them.

"Mrs. Robert Green of Wendte is up and about.

"John Jones of Belvidere is admitted for tonsillectomy.

"Dorothy Lewis of Fort Pierre had a mastoid operation at the beginning of the week; today she is sitting up in bed doing school work.

"Ben White of LaPlant is wanted as donor for a blood transfusion. He is working on a W.P.A. project near Isabel. Will someone hearing this message please see that he is informed. Tell him that satisfactory financial arrangements have been made. The doctors

would like to talk to Mr. Black of Java and suggest that he be at the hospital tomorrow morning at 8:30 o'clock.

"Henry Brown of Draper is daily growing weaker. The doctors hold out little hope for his recovery.

"Hugo Harris of Draper had an emergency operation last night. Mrs. Harris is here with him. On account of the bad weather Mrs. Harris cannot come home today and would like to have any one hearing this message ask the neighbors if one of their boys would look after the cattle, open the ice in the dam and haul straw to last until she gets home to make further arrangements.

"Clifford Peters of Okobojo is very sick and may not have any callers except the family."

Mr. Kienholz delights in recounting what he terms the most humorous message the hospital has been asked to broadcast. "One lady was taken suddenly ill. She was rushed to the hospital and later discovered that she had lost her earrings. She had arranged for the washing to be sent to a neighbor before she started for the hospital and she thought possibly the earrings were somewhere in that laundry. So for several days the station broadcast that the neighbor doing this washing should keep a weather eye out for the earrings. We heard afterward that the earrings were found in the laundry."

It's Good Publicity

• "Boosters instead of kickers" is the slogan adopted by E. W. Jones, director, Albany Hospital, Albany, N. Y. This accounts for the groups of men and women you are likely to meet on New Scotland Avenue almost any night on their way home from the hospital.

Let's inquire of that gentleman with the knowing expression. "We're members of the Albany Chapter of the National Cost Accountants' Association," he explains, "and we've just had a meeting at the hospital. We saw the whole works. Some place, I'll tell you."

Another night it may be the Junior Chamber of Commerce, the Industrial Club of Albany, the Wellesley Club or the Zonta Club. All express the same enthusiasm over what they have seen—excellent salesmen for the institution, every one of them. And what hospital does not need salesmen!

The list of organizations in Albany is carefully studied by Mr. Jones to determine which will be invited to

hold one or more of their regular meetings at the hospital. "Unfortunately," he explains, "we are not equipped to take care of any organization having many more than seventy-five members.

"At all of these meetings the organization usually comes in about 5:30 p.m. and is split up into small groups of four or five and conducted through the hospital. Following this we usually have a dinner for which the visitors pay 75 cents or \$1 depending on the menu. After the dinner I give a short talk on general hospital problems, which is followed by a question and answer period. We have found people so interested that they often spend from 9 until 11 o'clock asking questions about hospital work. These club members who have had an opportunity to learn something of the hospital are excellent salesmen for us throughout the entire community."

Tale of a Table

• There is a story about that new operating table of which Grace Hospital, New Haven, Conn., is so proud! It has to do with organized labor, but not organized labor as we have come to know it of late. In this instance hospital employees organized to make a gift to the institution they serve—a gift of an operating table. No fairy tale this. Just listen; it's Sidney G. Davidson speaking.

"In the August issue of our 'Grace Hospital News,' we stated a need of contributions toward a fund to purchase a new operating table. Shortly afterward one of the orderlies came to me and asked if I would approve of the orderlies, porters, maids and kitchen help, representing a group of between 100 and 110, holding a dance at the Young Women's Christian Association for the purpose of raising some money to put toward the fund. Their plan was to sell tickets for 40 cents apiece and raise what they could.

"They then started getting advertisements for a program. They worked every minute of their time off duty. Some of the girls made candy at home nights, and of course the doctors, board members and others bought tickets.

"A friendly and philanthropic member of the community upon hearing the story was so impressed with the loyalty and interest of these employees that he offered then and there to match dollar for dollar all that they raised. That provided an additional incentive.

"The dance was a great success, and as a result these faithful workers had the thrill of turning over to the hospital a check of \$250. This amount our friend doubled."

For Hospital Day Honors



SINCE there are now four national awards made for the best observance of National Hospital Day, May 12, interest in the competition has increased. The American Hospital Association offers two awards for the best observance of the day: one to hospitals in cities of 15,000 population and more and the other in the smaller places. Two special publicity awards are also offered, one for the larger and one for the smaller cities. In addition some state hospital associations are making awards.

A pamphlet giving extensive suggestions for the observance of National Hospital Day has been mailed to all hospitals in the United States and possessions. Any hospital that failed to receive a copy or wishes additional copies should write to the chairman of the committee, Albert G. Hahn, Protestant Deaconess Hospital, Evansville, Ind.

In preparing material to compete

for an award, a hospital should make up an extensive and comprehensive summary of its observance. This summary might well include the following.

1. A descriptive outline of the entire program from the time the first plans were laid until the date the report is prepared.

2. A series of good photographs of the highlights of the observance. It is well to have some amateur or professional photographer on hand taking pictures of the most dramatic, appealing or unusual aspects.

3. A statement of the number of minutes devoted to radio talks, dialogues and dramatizations on National Hospital Day together with copies of the scripts used.

4. Copies of all printed material employed.

5. Scripts of plays, dramatizations, speeches and similar presentations.

6. Record of the number of column inches of newspaper stories, together with dated clippings of the stories.

7. Record of the number of people invited and number attending.



Above: Prize winners in annual baby contest at St. Luke's Hospital, Jacksonville, Fla. Top of page: Part of film taken at the same hospital and displayed in local theaters. One lone father may be seen, looking just a trifle sheepish.

In previous years the committee, in granting the A. H. A. award, has paid particular attention to the skill with which the hospital appeared to have utilized National Hospital Day as a method of building lasting public interest and support. The best observance is the one that makes the most constructive and lasting impression. One hospital, for example, celebrated National Hospital "Day" over a period of about six weeks, inviting different groups of high school pupils in the city and near-by towns to visit the hospital, where they were instructed in the important aspects of hospital service, particularly those of interest to adolescents. On May 12 the hospital program was pointed toward adults chiefly.

In making awards, the committee is interested in the quality of the program as much as the quantity.

Summaries should be prepared and sent to state chairmen by July 1.

Ideas that could readily be adapted for National Hospital Day were developed recently when Vassar Brothers Hospital, Poughkeepsie, N. Y., celebrated its golden anniversary. A three-day celebration was arranged, the first day devoted to the nurses, the second to the public and the third to the doctors.

A nursing institute on the first day included discussions of highlights in the growth of the hospital, hypoglycemic treatment, fifty years of nursing, mechanical treatment of peripheral vascular disease with Buerger's exercises, child guidance, postoperative treatment, new therapeutic agents and a historical skit. Approximately 125 graduate nurses attended. Tea was served in honor of the four living former superintendents of nurses, three of whom were in attendance. A hobby show was on exhibit.

The open house on the second day attracted 800 visitors. Special exhibits included a tilting board, an oscillating bed, an oxygen tent, a fracture bed, passive vascular exercise boot, a respirator, an incubator, a cracked ice container and material showing the work of the nutrition department, the Junior League, the women's auxiliary and the hospital care insurance plan.

Concurrently a well-baby clinic and baby contest were conducted in



A section of an exhibit at Touro Infirmary, New Orleans, which had many visitors.

the out-patient department. Refreshments were served, of course.

A community meeting in the evening was addressed by the president of the board of trustees and the mayor, with a showing of "Good Hospital Care" and singing by glee clubs. A pageant depicted the history of nursing.

The doctors' day program included surgical, orthopedic and medical clinics in the morning and a series of three papers by nationally known physicians in the afternoon. A joint dinner of the trustees and the doctors in the evening was addressed by Dr. Matthias Nicoll, commissioner of health of Westchester County, on the subject, "The Medical and Economic Aspects of the Hospital of the Immediate Future."

The anniversary program was advertised by means of displays in three of the downtown stores; parading of the hospital's 45-year-old horse-drawn ambulance; milk bottle collars, announcements in churches, high schools and service clubs; show cards in stores; letters to the parents of student nurses; stickers on letters and billheads, and a series of informative six-page leaflets mailed to more than 5000 residents of the community.

A historical sketch of the hospital was mailed to a selected list of 1000

persons. Excellent newspaper publicity appeared in the daily and weekly papers in the county, including illustrated stories showing what happens to a patient from admission to discharge and excerpts from congratulatory messages from notable persons in professional and public life who had at one time been patients in the hospital.

Several other hospitals report that they spread National Hospital Day observance over more than one day. Moline Public Hospital, Moline, Ill., for example, last year had a three-day observance coinciding with the opening of its new building. It began with a dedication banquet. On the second day the local medical society and its auxiliary held a meeting at the hospital and toured the building.

On hospital day itself a flag pole presented by the boy scouts was dedicated and an alumnae room and Florence Nightingale Hospital Circle room were also dedicated as features of the observance.

In smaller cities movies taken on the day are often shown in local theaters and thus a wide audience is assured. Most hospitals report great public interest in the institution's special equipment. The wise administrator is sure to take advantage of this type of appeal.

Key Positions

JOSEPH C. DOANE, M.D.

THERE is an atmosphere or attitude toward the visitor that even unperceptive persons sense upon entering a hospital. The hospital may have an air of quiet dignity, with subdued voices and evident courtesy everywhere, or it may have a boisterous, noisy semblance of efficiency, or it may even exude rank discourtesy.

The "x" quality, which attracts or repels, is as difficult to name as it is to describe. It may perhaps be called the "administrative attitude."

Various psychological attitudes must be employed by those who perform administrative functions. These functions may be classified as follows: (1) price setting; (2) collections; (3) greeting the patients' friends and relatives in happy moods, and (4) sympathizing with friends and relatives of patients in times of distress.

In most hospitals the credit function is assigned to a credit officer, who knows the psychology of avoiding conflicts. The credit office must protect the hospital against patients who, often honestly, are attempting to obtain hospital care at least possible cost. Without showing his knowledge of the fact, the credit officer must be able to identify those who are intellectually and morally dishonest. Upon recognition of this type, he must be diplomatic about avoiding loopholes without giving offense.

Through his attitude the credit officer must never evidence a defeat, must never flinch from naming the price of a room or service and must never reveal his belief that the patient cannot meet the cost of hospitalization.

Some credit workers become so sympathetic to the cause of the patients that they forget they are being employed by the hospital. It is not the credit man's duty to assist the patient in obtaining money. It is his function, after ascertaining the financial ability of the patient, to guide the patient in the choice of an appropriate type of service.

It is the function of the social service department to discover for the credit officer how bills may be met. Sometimes the social service

department handles credit, although this practice is not to be recommended. Patients are inclined to be reticent in answering questions necessary for a good social history if they believe that their answers may be used to increase their indebtedness to the hospital.

The person who sets prices should assume that the patient can pay. If he assumes that they are unable to do so, the patient or his relatives may be too readily inclined to agree.

The editor discusses some important posts in the administration of hospitals that directly influence the attitude of the public

Good credit officers are rare. They are likely to be either too inflexible or else too sympathetic and, consequently, unfair either to the patient or to the hospital.

There is no simple yardstick for setting prices quickly. The question arises, should the patient be required to meet the hospital rates or costs or should the price depend upon the patient's economic ability? Certainly private, semiprivate or ward rates should not be rebated unless unusual circumstances exist. It is unfair to frank a private room to save the self-respect or the social standing of an individual who patently should pay for semiprivate or ward service.

It is questionable whether or not the clergy or similar professional classes should expect or receive private room franking. In some hospitals this practice is far too extensive. In one institution, for example, 14 per cent of the free service was given to individuals who occupied private or semiprivate facilities.

In some hospitals other department heads are given the authority to abate or rebate charges. An x-ray director may well be permitted to frank charges for personal examinations of physicians who patronize his department or dependent members of their families. Such a policy should be formally stated and approved by the board of trustees and given to the department head to execute instead of *carte blanche* permission to make exemptions.

The mere statement that a patient cannot pay is not sufficient cause to throw the rate card into the waste basket. Few persons have sufficient judgment to be given full authority to make or rebate rates, and flexible rates often involve the hospital in complicated situations.

Those who are in a position to make collections should never appear apologetic. At the cashier's desk in a first-class hotel the departing guest receives a courteous "Thank you." The cashier expresses hope for a pleasant return home and for the pleasure of entertaining the guest again. Such an attitude should be expressed by hospital cashiers also.

There should be no fawning or eager avidity in accepting the patient's payment. If, because of an institution's policy, checks cannot be accepted, they can be rejected without offense and a suggestion as to the solution of the problem can come from the cashier.

A famous national park hotel, as a good-by token, not only prepares a lunch for the guest to eat while on his return journey, but also presents some inexpensive, but attractive remembrance of his stay. Hospitals, likewise, can create a favorable impression by presentation of an attractive envelope with a "Good-by, Good Health" card and a tab or two of individual hospital matches or other novelty.

A good impression tediously built up over days of hospital stay may

be ruined by the final contact at the cashier's desk. When the bill needs adjustment, this is frequently left to a tactful administrator. The patient is courteously conducted to the administrator's office, not sent by the pointing of a finger and left to inquire his own way. When a patient has been charged for a whole cylinder of oxygen and has used only half, or when a prescription has been filled but not used, or a packaged drug, from which but one unit has been taken, is charged to the patient, bickering may ensue.

An unpleasant argument concerning these minor matters or an adamant attitude toward changing a bill has more than once ruined an otherwise good impression. There is no reason for a hospital employee to lose his temper. To send away a dissatisfied patient or family is an acknowledgment of failure.

Those who meet relatives and friends in happier moods find it easy to be congenial and friendly. The receptionist in the hospital lobby should present a smiling countenance. The nurse who expresses joy at the improvement of a patient renders a distinct service.

Have you ever observed the floor nurses of a ward gather to speed the departure of a patient who has almost miraculously escaped death? Sharing such joy brings pleasure to the patient and his relatives. Birthday cakes presented by the dietitian, Christmas trees, the celebration of holidays, all help to make the hospital a joyous place and one to which patients like to return after they have been away many weeks or months. It is a real compliment to a hospital when a patient returns to seek out those who cared for him. This often occurs at nurses' commencements, hospital receptions and other social events.

Those who contact patients and relatives in times of stress should search for a word or an act that will lessen mental distress and create hope. One administrator, on an evening round, observed a group of distraught relatives of a semiprivate patient standing anxiously about a drafty retiring room. He opened a private room and permitted the anxious night watch to take place

under more comfortable surroundings. He ordered sandwiches and coffee to be served at midnight. The expense to the hospital was as nothing compared with the favorable comment that spread through that community.

The nurse in the accident ward has splendid opportunities to study the attitudes of human beings in distress. Her task, perhaps, is the most difficult in the institution. That relatives may not be permitted to observe the suturing of a head wound, a tactful nurse administrator will guide them to a convenient sitting room.

When this minor operation is finished, word should be sent that the patient may be seen. In the case of a critical accident, it is of the highest importance to send promptly for a clergyman or relatives.

The nurse should understand that irascibility, impatience and discourtesy are qualities engendered by distress and that they should never be returned in kind. Every wound, no matter what its dimensions, is of major importance in the mind of the frightened parent. Shocked nervous systems play curious pranks. Ex-

aggerated tales of crudities reported as cruelties emanate most frequently, perhaps, from the hospital's accident ward.

The highest test of administrative skill comes when a nurse or physician is required to tell a relative of the sudden death of a patient. This cannot be accomplished in a few minutes.

It often may take an unaccountable length of time to prepare the mind of the recipient properly for the stark truth. Crudeness here becomes cruelty and often terseness inflicts unnecessary pain. A sudden death is difficult to report. In cases of chronic illness, nature kindly prepares the relatives for the completion of the chapter.

Those who are expected to fulfill the function of fixing prices, of receiving monies, of greeting relatives and friends in happier moods would not be prepared to meet this task. The need for training persons to display the mental attitude necessary for these four different functions is always present in institutional work. As rapidly as such training is accomplished and put into effect, the visitor will sense it.

What an Executive Needs

A GROUP of executives engaged in social work recently prepared a list of the qualities that an executive should possess (*The Survey*, January 1938). The list, abbreviated and slightly modified by Dr. S. S. Goldwater, is as follows:

1. Ability to inspire, stimulate and build the morale of the staff; capacity for group leadership.
2. Special knowledge of at least one phase of the work.
3. Ability to take decisive action, to get things done; practicality.
4. Stability and constancy, *i.e.* possessing "iron"; not vacillating, but not unyielding because feeling insecure.
5. Objectivity, fairness, lack of prejudice.
6. Self-confidence, coupled with humble-mindedness in the areas in which he lacks competence.
7. Ability to accept criticism profitably.
8. Ability to delegate work.
9. Initiative and originality.
10. Capacity and enthusiasm for mental growth.
11. Pleasing manner, ability to verbalize, facility in meeting people, liking for people.
12. Ability to write clearly and fluently.
13. Good emotional adjustment.
14. Ability to interpret the work to the public.

A Patient's Lament

SAMUEL PARLETT

PART II

WHEN a campaign is on for funds the public is informed that Blank Hospital is established solely for the benefit of the surrounding community. Healing the sick is the only function that it stresses publicly. Only in the right sort of places, where the public probably will not hear of it, do hospitals boast of their facilities as graduate schools for young doctors and training schools for nurses. The clinical material to be used are the patients.

When a patient enters a hospital he selfishly and quite naturally thinks that he will be regarded solely as one to be made well and not as one who, under cover of scientific expediency, may be, and often is, subjected to procedures having nothing whatever to do with his personal comfort.

This is a feature of hospital management that a layman should not overemphasize for there is abundant evidence that hospital administrators are aware of it. Nor should the layman feel that, within reasonable bounds, there is anything radically wrong with this education. There is no reason why the young doctor and nurse who give their time in return for education should not learn whatever they can incidental to the care of the patient. Abuses develop, however, when practices are followed that are not incidental, and the abuse is heightened because they can be made to appear incidental except to those behind the scenes.

Unnecessary "Treatments"

In one hospital where the moribund were callously permitted to die on the ward in full view of fellow patients, a postoperative case was dying. Periodically, during the day before the end, an intern appeared to take blood specimens from the patient, although the patient feebly begged and had a right to be left in peace. It is a safe bet that, if that

luckless patient had been the intern's father, he would have found good reason to refrain from what he euphoniously referred to as "treatments."

In another hospital a young boy was dying on one of the wards in full view of fellow patients. He had something "interesting" in his chest in the way of effusions which gave off a most intriguing sound when the patient was shaken. During the day of his death there must have been at least ten groups of interns and students at his bedside shaking him in order to become familiar with these sounds. Doubtless much was learned from this procedure by these future guardians of our health, but it was rough on the patient!

Starched Supernurse

I have observed, but never directly addressed, the principals of training schools of which I formed part of the teaching material. These women obviously carried burdens too great for any one person to bear, as shown by their demeanor. This was as intense and starch-like as the unyielding collars which most of them affect. Frankly, I have never spoken to any of "these women" because they seemed to be chronically unable to see me after months of stay in the hospitals under their supervision. They seemed to see only the bed and the mark on the floor that indicated the position along which each bed must be lined up.

This supernurse, as far as the patient is able to judge, is not a nurse at all, but a teacher of nursing who is making a pedagogic tour to determine how her pupils have learned their ward lessons. The bedspreads must be geometrically squared and the beds, chairs and tables precisely aligned. In all my years of residence in hospitals with training schools, not until recently have I seen a superintendent of nursing stop at a bedside

The second and final installment of an article published in the February issue. It relates the sad experiences of a chronically ill patient who spent ten years in 12 different hospitals

to say a few words of comfort to a patient.

The patient is presumably given medication and other treatment which, in the judgment of the medical staff, are indicated clinically. This is not always the case and the patient may be made to suffer because a "peeve" is being worked out.

For example, I recall a dance given at a hospital to which the interns were invited. One intern had tendered several invitations to a student nurse (my informant) to "step out" with him and had met with refusal. He made his final attempt by inviting her to attend this dance and, being refused, promised to square accounts by ordering fifteen enemas for the following morning which she would be obliged to administer. The enemas were ordered and duly given.

I have been well fed in only two general hospitals and neither of these was a municipal hospital. The food in most of the hospitals is poorly prepared, whatever quality the food may have been in its raw state, and generally is scanty. In the matter of food there are strong likes and dislikes.

It is naturally quite impossible to please everyone in his food tastes. With the sick the problem is aggravated. However, it is not often that hospitals make a serious attempt to spur a jaded appetite. Cuts of meat are often leathery in quality and vegetables soggy, if there are any vegetables other than boiled potatoes. Soups are too often insipid, there is

a lack of variety, and service is too often slovenly. How can a patient eat while a great many things are going on in the ward that destroy his appetite?

Don't be too ready to condemn contraband food that is smuggled into the hospital by the patient's family. It is often a lifesaver. Put yourself in the patient's place. While a patient in a world-famous institution, I bribed kitchenmen to purchase canned beans, being a Bostonian, and to heat them on the days when I was exceptionally hungry. It is pertinent to state that the ward rate was a high one and should have included much better food than it did.

I am quite familiar with the dunning methods used by the average hospital cashier. I have seen this official appear on the ward and loudly and shrilly berate a patient for not having made his payments when they came due. He reminds the patient that "this is no hospital for free treatment," and that he would be removed to Bellevue if payment was not forthcoming within a specified time. In several instances, the transfer was actually made. The effect of such humiliation on the patient can well be imagined. City marshals engaged in eviction proceedings are more kindly in their expressions than some fiscal officers of philanthropic institutions sometimes appear.

The closeness of one suffering patient to another on public wards is not helpful to the treatment of either. In one hospital the beds were pushed so close to the intervening bedside tables, that a patient turning in one bed would transmit tremors to his neighbor. Stories of crowded accommodations in municipal hospitals are advertised to impress the taxpayer. Perhaps in some cases this cannot be avoided, but in the meantime patients are subjected to hardships.

Finally comes the discharge of the patient. More likely than not he carries memories of an institution operating as a philanthropy which, so far as he is able to judge, has done an efficient job on him as an ailing mechanism, but which was somewhat careless of his rights as a human being. He comes away with the impression that there are few who

will take his part and that even the front office is partly, if not completely, deaf, dumb and blind to most of his needs.

In those cases in which the bolder patient makes a complaint it is easy to discredit him by the evidence of his clinical chart which will invariably show that he is complaining because he is sick and, therefore, mentally disoriented.

The reader may think that I have adopted a defeatist attitude toward hospitals. This is far from the case, since I have come to learn from personal experience, how much can be accomplished by a cooperative hospital administration. First of all, the trustees must determine that the causes of such complaints shall be abolished. Second, personnel should be selected carefully on the basis of kindness to patients and professional efficiency. It is of the greatest im-

portance to have all groups work cooperatively to achieve the highest comfort for the sick.

Furthermore, it is important that the administrator of the hospital himself, or his assistant, shall be personally familiar with every patient in the hospital by name. There must be a clearing house somewhere for complaints. Unkindness to a patient should be made a capital offense, punishable by summary dismissal. Reprisals against patients who complain must be prohibited. The giving or accepting of bribes by patients or employees must be dealt with severely. From the point of view of the patient the best way to achieve this desirable result is to make him feel that he will receive all of the attention that he needs without additional subsidy to anyone. Eternal vigilance is the price of safety for patients, as well as for normal individuals.

Isolation in the Small Hospital

PROPOSALS for the care of communicable diseases in small general hospitals, advanced by the committee on small hospitals of the Canadian Hospital Council, offer some solutions for this problem in communities in which there is no isolation hospital.

The committee pointed out in its report that the boards of trustees of small hospitals should consider the provision of isolation facilities either through an addition to the hospital or by remodeling a wing or a floor.

As an alternative, the committee suggested placing the responsibility for communicable disease patients upon the municipality. Since provision of isolation facilities by a voluntary hospital for outside patients might properly be financed by the municipality, both for capital and for maintenance expenditures, such an arrangement is less expensive for the municipality than for it to build and maintain a municipal isolation hospital. Such a unit would then receive cases both from the general wards and from outside the hospital.

An isolation unit in the general hospital should have beds, chairs,

tables, the usual linen and plenty of gowns for the doctor and nurse, as well as all articles needed in caring for the patients, running water and bathroom facilities. It should be equipped with facilities for disinfecting dishes, linen and body waste.

Experience in the nursing technic of communicable diseases makes the nurse an efficient agent in the promotion of personal and social hygiene; this is an important quality in a nurse in either a large or small general hospital.

With a background of theoretical training in communicable diseases, the nurse learns the approved method of control and the conscientious application of rigorous aseptic technic in the isolated unit. She always uses isolation technic for questionable cases until the final diagnosis is made. She knows the value of immunizing agents, the necessity for preventing contacts, the need for decreasing morbidity and mortality.

Vigilance should apply in the care of all patients in general hospitals, as the nurse cannot be aware of the hidden communicable diseases that may be present in emergency cases.

The Case for Air Conditioning

TO AIR CONDITION or not to air condition—this proposition troubles and intrigues hospital administrators, regardless of size of the hospital or climatic location.

Some administrators have gingerly tested the water of public opinion and practical economy by making installations in one section or in a few rooms of the hospital, meanwhile keeping a weather eye open to improvements and to the results of testing and experience. Others, more venturesome, have installed air conditioning in entire wings or throughout the hospital.

Whatever the experimental route has been, the reaction to new methods of temperature control have been overwhelmingly favorable. Administrators have been quick to see the trend toward air conditioning and have been imaginative enough to develop new uses for the equipment.

The use of air conditioning in hospitals is proceeding at a cumulatively faster pace. A questionnaire survey conducted by The MODERN HOSPI-

TAL and the American Hospital Association's committee on air conditioning brought forth replies from approximately seventy hospitals. Of these only four had installed their equipment in 1930 or earlier and only seven in the years 1931-33, inclusive. Sixteen of the hospitals made installations in 1934, twenty-five in 1935 and in the first eight months of 1936 there were sixteen installations.

The East North Central group of states comprising Ohio, Indiana, Illinois, Michigan and Wisconsin, took the lead with air conditioning installations of eighteen out of sixty-nine reporting. The South Atlantic group was second with eleven.

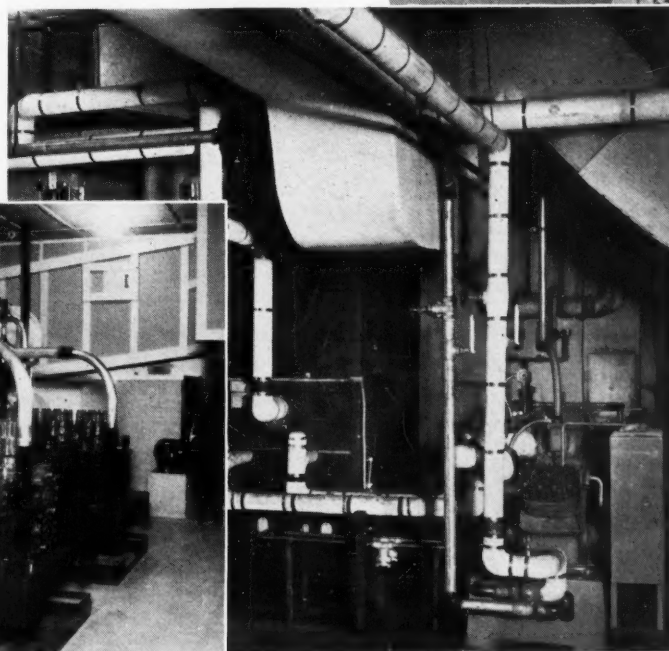
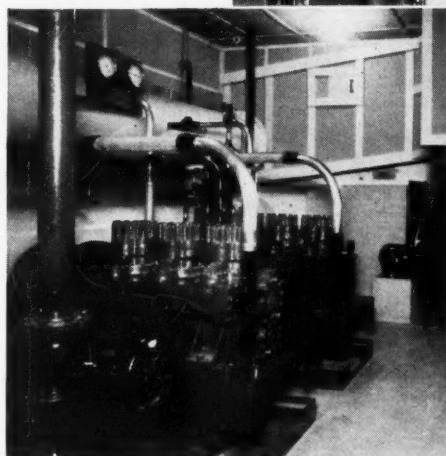
The size of hospitals using air conditioning indicates that this convenience is of interest to hospitals of all categories. There were seventeen hospitals of less than 100 beds

using air conditioning, fifteen of 101 to 200, fifteen of 201 to 300, nine of 301 to 500, 7 of 501 to 1000 and four hospitals of more than 1000.

General hospitals far exceeded all other types using air conditioning. Up to the time of the survey only two hospitals had been reported in which the entire building was air conditioned. (Subsequently at least two more have been described in MODERN HOSPITAL: Corey Hill Hospital and Moline Public Hospital.)

When separate departments are air conditioned, the operating suite is apparently the first to be cared for. More than forty-seven installations in operating rooms were reported. Next in frequency are nurseries with twenty reporting, private rooms with seventeen reporting, delivery rooms with fifteen and anesthesia rooms with ten. Other types of installation reporting are given

Machinery for a central system and a compressor with automatic control are shown below and at the right.



Portable units are satisfactory for cooling private patient rooms.

in detail in the accompanying table.

The data on size of plant are incomplete but plants apparently vary from less than 1 ton of refrigeration, of which three were reported, to 100 tons or more, of which there were four. In the 1 to 5-ton group there were eleven installations; in the 5 to 10-ton, four; in the 10 to 15-ton, seven; in the 20 to 30-ton, six; in the 30 to 40-ton, five.

Fifty-four hospitals reported that they use a central system and thirty use individual room coolers. Several, obviously, use both types in different parts of the institution.

The cooling agent used most is freon, which was reported by forty of the hospitals. Refrigerated water and naturally cooled water were each used in thirteen installations; carbon dioxide and sulphur dioxide each in three; methyl chloride and brine with two each, and ammonia with one. Of fifty-five hospitals reporting the make of compressor used, three firms supplied compressors to thirty-four of the hospitals. The remaining compressors were supplied by eight different firms.

Wide variation in opinion as to the most satisfactory relative humidity in various parts of the hospital was recorded by the correspondents. In the operating room, for example, the optimum humidity was set at 35 per cent in one report and 80 per cent in another. The most frequent figures, however, were 50 per cent and 60 per cent.

Relative Humidity Varies

In nurseries the range was much more restricted, the lowest per cent of relative humidity reported being 45 per cent and the highest, 65 per cent with again the bulk of respondents favoring 50 to 60 per cent. For patients' rooms, 50 per cent seemed to be the most frequent figure.

The data on costs of installations were incomplete and need considerable interpretation to be of value to others. The lowest cost reported was \$345 for the air conditioning of a single nursery. The highest amount was \$25,000 for five operating rooms, four recovery rooms, one ward, one sterilizing room, one nurses' workroom and fifteen other rooms.

Some sample costs reported were as follows: two operating rooms and two recovery rooms, \$4250; six operating and three surgeons' rooms,

Portions of Hospital Conditioned

Room or Dept.	Hospitals Reporting
Whole building	2
Operating room	47
Nursery	20
Private room	17
Delivery room	15
Anesthesia room	10
Miscellaneous	9
Labor room	8
Laboratory	8
Recovery room	7
Business office	5
Semiprivate room	4
X-ray room	4
Incubator	4
Examining room	4
Dining room	4
Nurses' room	4
Lobby	4
Emergency room	3
Sterilizing room	3
Therapy room	3
Research room	3
Lounge	3
Kitchen	2
Oxygen room	1
Allergy room	1
Clinic	1
Employees' room	1

\$4139; six operating and three private rooms, \$9000; three private rooms, \$2800; two operating rooms, \$1100; three operating rooms, \$9000; three operating rooms, \$6500; five operating rooms, \$2000; three operating rooms, \$2750; sixteen operating rooms, \$23,000; sixteen operating rooms, \$20,000.

Apparently it is uncommon for hospitals to charge patients for air conditioning as few figures were given. A few hospitals charged from \$1 to \$2 a day; when this was done the income for the four summer months was well in excess of the estimated operating expenses for the period.

Interesting comments on air conditioning in hospitals were made by several of the correspondents. Samples of these follow:

"To date our experience with air conditioning has been confined to one portable unit and one unit of a central system," writes the superintendent of a large eastern hospital. "Both have been used in private patient rooms and have given satisfaction to the patients. The central system is a water cooling system and it is our intention to install fifteen more units in the near future."

"We are interested in two features, namely, cooling and dehumidifying,"

says the administrator of an eastern hospital of more than 200 beds. "The purpose of the units is to make the patient as comfortable as possible. We have used it principally for post-operative cases and the comfort that patients receive from the cooler, drier atmosphere brings them through the critical postoperative period in far better shape. We can definitely say that several lives have been saved and many patients have been made more comfortable."

System Is Unsatisfactory

"We find that this equipment is expensive to run and maintain and necessitates the constant attention of our maintenance man," is the adverse report from a St. Louis hospital. "Ours is a carbon dioxide system working under high pressure and there is the danger that the safety valve may pop off at any instant and allow all of the refrigerant to escape. During the summer the water used to cool the condenser coils reached a temperature of 87° F., and at this temperature it was impossible to use our cooling system."

"The remedy will likely be either to change to another type of refrigerant, such as freon, or to use cool water from the water cooling system to cool the condenser coils."

"Cooling is required in St. Louis from thirty to one hundred days, depending upon the season. This year only forty days of cooling was needed for the operating rooms, but cooling was in demand in the patients' rooms for most of the time."

"We try to keep our operating room temperature not below 80° F. and at about 55 per cent humidity. The humidity might be lower for body comfort but not for the prevention of static sparks. We do not know of any bad physiologic effects of moving patients from cooled air, as long as the differential is not greater than fifteen degrees."

"I am convinced that air conditioning in hospitals is about as necessary as a heating plant," says the head of a small hospital serving chiefly industrial patients. "We had a chance to observe a large number of heat exhaustions this summer and every one reacted well."

The director of a university hospital in the South states, "I feel at the present time that air conditioning for hospitals is in its infancy, but



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that provisions should be made in the construction of hospitals in the future so that air conditioning could be installed at minimum cost.

"Further provisions should be made to air condition the hospital in its entirety. Disastrous results might follow the air conditioning of certain parts. In our layout for a new hospital we are planning a duct system that will completely air condition this new unit."

"Last summer we had admitted a patient who was in a most serious condition," writes the superintendent of a state hospital in the East. "During his stay at the hospital a portable air conditioning outfit was installed. After the patient was discharged we found the paint on the ceiling particularly, and also on the walls, entirely loosened from the plaster.

"No other room had ever presented such a condition. The cooling agent used was natural cold water. The approximate temperature maintained in the room was between 70 and 72° F. I doubt if the humidity registered more than from 30 to 35 per cent. We should like to know whether other institutions have had similar experience."

Essential in Operating Room

"We are convinced that no modern operating room is adequately equipped without air conditioning and this also applies to the nursery," asserts the administrator of a Pennsylvania hospital.

"We did not install a unit in our nursery but are now seriously considering it, particularly to humidify the air in winter, which otherwise tends to dehydrate the newborn and retard their initial development. We do not feel that air conditioning is essential in private rooms unless certain of them are to be assigned to asthma or hay fever patients."

Declares the head of a large Michigan hospital: "We have a few private rooms air conditioned by means of separate units. As regards the cost of operating, this is nothing. Indeed, it yields an actual profit since the water warmed by the hot air is returned to our boilers and makes a saving in coal consumption that amounts to an estimated 75 cents per hour. The cost of running the fan is 17 cents an hour, so we make a profit of 58 cents an hour."

"Our obstetrics department was air conditioned three years ago and the operating department, two years ago," states the administrator of a small southern hospital. "We have never had any complication either to patients, nurses or doctors. In the operating department, in which we have four rooms air conditioned, it is so satisfactory that if, for any reason, the machine is out of order for a few hours, a surgeon will postpone his operation, if possible."

Agree on Value of Cooling

In answer to the question, "In general, do you feel that air conditioning has a significant place in hospital work?" only one administrator said "No."

"I feel this way," he declared, "because of the fact that there is too much change in temperature between the outside air and the room air. While it is extremely beneficial in hay fever and asthma patients, most patients do not seem able to pay for the additional expense."

"Our experiments covering four years proved conclusively," reported a midwestern university hospital, "that with practically complete removal of pollen from the air, which can be accomplished with the use of cellulose filters, complete relief can be afforded in uncomplicated cases of hay fever in from thirty minutes to one and one-half hours.

"Most cases of what were uncomplicated pollen asthma can be relieved to a marked degree by continuous confinement in pollen-free air. For such relief, however, from three to five days' continuous confinement is necessary.

"Some of these cases never become absolutely free of symptoms. An electric storm usually precipitated an asthmatic seizure even in pollen-free air. This ward was operated at a relative humidity of around 30 per cent at a temperature of from 78° to 80° F. These conditions contributed to the comfort of the patient and influenced favorably to some slight extent the speed of relief from symptoms."

From the Southwest, the superintendent of a hospital of more than 200 beds writes, "Although we have never had much infection to contend with in our operating rooms, we have found that wounds have healed perfectly since the use of the cooling

system. Patients have not perspired on the table and, contrary to popular belief, instead of increasing the susceptibility to colds, bronchitis and pneumonia, patients operated on in these air conditioned rooms are particularly free from such symptoms."

"It is our experience," says the head of a large hospital on the Gulf Coast, "that our air conditioning unit, which we have used for allergic patients, is a valuable aid in treating this type of patients. Recently a 70-year-old man developed a strangulated hernia which required an emergency operation. The patient was asthmatic. All the combined elements entering into the situation made the operation a grave risk. Following the operation the patient suffered extremely from his asthma and looked as if he would suffocate.

"He was placed in a room with an air conditioning unit and within two hours was entirely relieved from his asthma. From then on the case took an uneventful postoperative course. This is an extreme case, but our air conditioning has worked as effectively on many other cases.

Especially Equipped Room

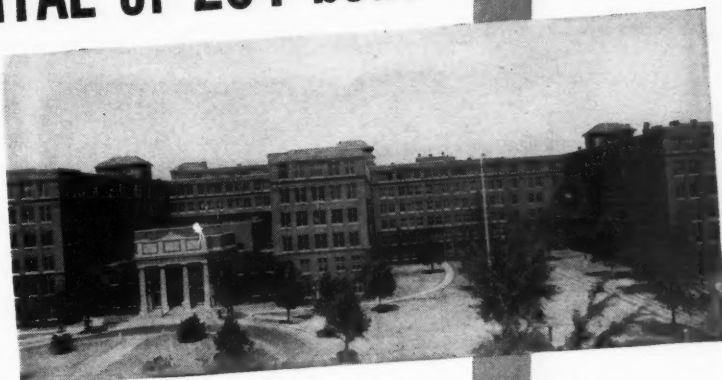
"The equipment in this room includes furnishings from which the dust has been removed and the mattress and pillows tightly sealed in rubber casing. Some patients do not respond to this treatment, but these cases are chiefly those with allergy caused by respiratory infections.

"I am convinced that air conditioning for operating rooms is worth while. We have had patients whose temperature was normal, yet after an hour or so in our operating room they showed a rise in temperature. Their fluid loss is tremendous and a condition similar to heat stroke occasionally develops. Air conditioning will greatly lessen this hazard and will also permit the personnel of the operating rooms to work comfortably."

The case for air conditioning is well summed up by an administrator of a Pacific Coast hospital. He says, "Our experience leads us to believe that air conditioned rooms should be furnished whenever the expense can be borne as just another service that hospitals and doctors should make available to the public. I do not feel that we should capitalize on this service; rather, it should be furnished at cost."

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THE Hubbard-Currence tank is a modification of the original Hubbard tank with several important changes. The design of the tank has been improved, both ends now being oval with all corners rounded. This improvement permits the technician to reach the axilla of the patient on either side without entering the tank. The patient is enabled to relax with his head on an adjustable built-in head rest.

Complete range of motion of all joints of the body is provided. The tank has sufficient inlets and outlets for rapid filling and emptying. It can be completely filled with water at any temperature or emptied in less than five minutes. The electrically driven turbines mounted in the tank produce an efficient form of gentle massage that can be applied directly to the affected part.

A thermostatic water-mixing valve of sufficient capacity, with volume control, provides for rapid temperature changes, which are accurately indicated on a dial thermometer. Patients incapacitated and unable to enter the tank unaided may be swung on a stretcher supported from an overhead carrier and safely lowered into the tank. The overhead trolley also permits the use of a belt in which the patient may swing and attempt swimming motions in an effort to aid joint movement.

Briefly, the numerous advantages of tanks over pools for underwater therapy are:

1. Greater cleanliness, since the tank permits rapid filling and emptying and may be easily cleaned.
2. Accessibility of the patient to the technician, who can reach every part of the patient's body at any time without entering the tank.
3. Ability to change the temperature of the water rapidly. This feature is the key to the superior results accomplished in the treatment of arthritis and rheumatic affections.
4. Application of controlled hydro massage not possible in a pool.
5. Ease in handling nonambulant patients.
6. Improved health of technicians, as long hours in the pool are hazard-

An electric turbine, mounted on a carriage permits movement as needed. An aerator embodied in the turbine introduces and mixes air with the water, producing quantities of air bubbles which intensify the heat and massage action of the water.

ous and attendants often develop dermatologic conditions and colds.

7. Low cost in comparison to the cost of a pool.

Osteoarthritis, rheumatoid infection, after-care of paralyses following anterior poliomyelitis, hemiplegia, fractures and various types of chronic infections have been treated successfully in the tank.

In treating osteoarthritis, without foci of infection, the patient should be hospitalized for three or four weeks with no weight bearing permitted during the first two weeks and, in obese cases, for a much longer period. Hydrotherapy never cures but there is rapid improvement that is often spectacular, especially in senile cases. The patient is immersed in the tank at approximate body temperature; within five minutes the temperature is increased to



the point of relaxation and relief, usually from 104° to 106° F.

Arteriosclerosis, cardiac disorders or high or low blood pressures require less dosage and closer supervision. The patient's temperature, by



M. BURNEICE LARSON, DIRECTOR

PHYSICIANS, HOSPITAL ADMINISTRATORS, GRADUATE NURSES, DIETITIANS, TECHNICIANS

Tell us....*write* us.....that you want *pleasant*, understanding people,
with minds that are trained and smart, hands that are
skillful, wills that are eager and earnest.

We *will* find them for you!

We'll find the finest men and women in the land, to give you personnel to make your hospital all and more than all you ever hoped for it.

You *need* not have less; you *can* have all of that and all that that would mean in finer, surer, greater work accomplished for every patient that would come to you.

The fame of all you do depends upon the nurses, doctors, surgeons that are yours. Steel and stone and modern ways have *much* to do but *less* than men and women. All the fiery,

starry hopes and plans you have are as they'd never been . . . unless your personnel has chins that tilt, and eyes that challenge every difficulty, and nimble, skillful fingers, and wisdom, and understanding, and eager intent, and comfortable pleasant ways.

You *can* have men and women such as those. We've spent our lives, have learned the ways to find them, have won their understanding faith and confidence. Write and ask for those you need. Tell us the kind you want. Finding them is our great work.

The MEDICAL BUREAU

55 E. Washington St.

The top floor of the tower of the Pittsfield Building
CHICAGO, ILLINOIS

mouth, need not be increased more than one or two degrees. The hydro massage is given to joints most affected. At this point the water temperature is reduced within two minutes to an exhilarating temperature at which relief and relaxation are maintained. This varies from 70° to 94° F. with individuals. Follow this procedure with from ten to thirty minutes of passive motion or active exercise under water. A full general massage should come next. Treatments are given daily over a period of from three to six weeks, then once each week, or the entire course may be repeated after from four to twelve months.

In cases of rheumatoid arthritis, with active or latent infection, the patient should be hospitalized and the dosage in time and temperature should be carefully prescribed until the reaction possibilities of the patient have been established.

Immerse the patient in water of about 100° F. increasing the temperature to 104° or 106° within three to five minutes; after a 1° F. rise in body temperature, rapidly reduce the water temperature to the maintenance point for from five to fifteen minutes as tolerated. During this period a few gentle passive or active movements of joints, with hydro massage, are indicated. Avoid causing pain, as it may induce an infectious exacerbation.

If no reactions occur within twenty-four hours, increase the body temperature dosage from ½° to 1° F. until mouth temperature of 101° or 102° F. is reached two or three times weekly. The total time dosage may then be increased to as much as thirty minutes. Passive and active underwater exercise is also increased and the dosage of massage is increased with caution. A rest period of one or two weeks should be given every four to six weeks.

Many publications recommend the usage of underwater therapy in the after-care of paralysis following anterior poliomyelitis. The optimum temperature for underwater rehabilitation, it is generally believed, is a constant one of about 86° F. A flat canvas hammock, 12 inches in width, may be swung across the tank and fastened to the brackets on either side, and the patient may rest on

this. At first, gentle passive motion is used with massage to the paralyzed muscles; as soon as the least sign of active motion is elicited, assistive movements are given along with active motion.

Gradually, as rehabilitation continues, gentle resistive exercises are given against the paralyzed muscles both manually by the technician and by resistive movements against the force of the turbine hydro agitator. The force is regulated by the distance of the involved part from the agitator and is slowly increased as the muscle power improves. Later, the patient is urged to reach for objects floating in the water at points sufficiently close so that he can be successful. For this purpose, kicking a floating ball or reaching for floating blocks or similar objects is indicated. With the return of function under water, exercises of a similar nature are given in the air to try to gain similar improvements without the assistance of the buoyancy that water affords.

For hemiplegia, treatment similar to the foregoing can usually be instituted within one month after the onset; the improvement is then more rapid and more complete.

The tank is useful in the after-care of fractures in cases in which function of the hip, shoulder or knee is involved. Smaller tanks are more efficient for extremities, but the large tank may be used even in extremity work, *e.g.* for a patient who has been in a spica cast for several months following a fracture of the femur near the hip joint. As soon as the cast is removed and gentle motion is permissible, daily treatments comparable to the treatments outlined for osteoarthritis may be begun. Frequently these treatments enable patients to regain almost normal function through their underwater exercises before the surgeon in charge feels that it is safe to begin weight bearing. As a result the total period of disability is materially reduced and the ultimate functional result is definitely better.

Suntan Marking for Infants

R. A. SEYMOUR, M.D.

FOR some time the Vancouver General Hospital, Vancouver, B. C., has had dual protection in the problem of identifying new-born babies. In the maternity block is delivered each year an average of 1700 babies. In busy times, such as recently when twenty-three babies were born in twenty-four hours, adequate protection to prevent babies from being mixed is paramount.

Records show that hospitals occasionally get into legal difficulties over this problem. The distress of parents under such circumstances can be understood. When hospitals can show their public that such errors are sufficiently guarded against, parents can be given complete assurance.

We use, in addition to the nursery name necklace, another means of identifying new-born babies that we call the suntan identification system. The name of the baby is tanned on its back through cut-out letters by a

water-cooled quartz lamp. This is actually done in the delivery room in the presence of the mother and before the baby is taken to the nursery.

The machine is brought into the delivery room and the whole process is explained to the mother if she is able to listen. Cut-out letters spelling the baby's name are set in the machine and placed against the baby's back. One minute of quartz lamp treatment produces a dull reddening of the skin which shows up in a few hours and lasts usually a little more than two weeks, then gradually fades. By this means the babies are definitely identified.

Within a period of six months the name can be brought back to the visual field at any time by means of a special "Woods" glass which shows up the areas that have been affected by the quartz light.

Parents are greatly pleased over this additional check and the mothers easily identify their own babies.

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A strong metal cap seals your solutions in a vacuum until you are ready to use them. No one can tamper with the closure without leaving unmistakable evidence. Once opened, a Vacoliter can never be resealed. This is an

added protection against damaged fluids. This is one of the many reasons you can use Baxter's Dextrose and Saline Solutions with confidence in their dependability. They come to you after their sterility and purity have been thoroughly tested.

Only Baxter's Solutions are Vacoliter protected. Add economy to these satisfying advantages and the three basic advantages of Baxter's Solutions stand tall and obvious: They are sterile and pure; they are economical; they are *convenient to use* in the patented Vacoliter, the first container-dispenser approved by the American College of Surgeons.

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CHICAGO NEW YORK



Handling Reserve Linen

MILDRED BURT

IN OUR housekeeping department we have adopted a perpetual inventory system to meet our needs in handling the reserve supply of linen available for use in our linen room. We have gone even further, and use the system in handling many of the items made and distributed to the various floors through the sewing room.

We are constantly receiving requisitions in our sewing room for the making of articles used in the hospital. In order to avoid delay in supplying those articles frequently called for, we make and stack on our closet shelves a sufficient amount of these to last us for several weeks.

In order to keep a careful and accurate record of the stock on hand and its distribution, we use Form 1, shown above, which gives full details of all transactions and is pinned on the stack of goods stored on the shelf.

As an illustration, we started with a supply of 301 face masks on No-

vember 15. On the stack of face masks was pinned the "tag," Form 1. By looking at this tag, we see that eighty-five masks were withdrawn on November 18 for the operating room and that on January 25, 100 were withdrawn for the maternity private corridor. On February 9, 12 and 13 withdrawals were made for replacements for discarded face masks in the operating room and maternity private corridor.

These entries were made by one of the employees of the sewing room who is near the closet. Not only withdrawals but additions to the store of face masks are shown on the tag. At the same time, the transaction is noted on the slip below (Form 2) so that the record is complete.

DATE	11/18/37
for	OR
CLOSET	B-15 BAL. 216
WITHDRAW	MAKE ADD
	85 Face Masks

Form 2

When a withdrawal or addition is made to the stock of face masks, the word "withdrawal" or "add" is encircled and the slip made out as above, the figure after the word "balance" always showing the exact number of masks on hand.

Form 2 is then placed with all such slips collected for the day on the desk of the housekeeper who has charge of linen and sewing rooms.

On her desk the housekeeper has a master set of cards similar in nature to the "tag" in the closet. Using on an average ten or fifteen minutes of her time daily, the housekeeper transfers the information on Form 2 to her own master cards (a sample

card appears below, Form 3), noting as she does so whether or not there is any disagreement between her balance and that on Form 2. If any difference is noted, an investigation is made to determine the cause, perhaps a mistake in figures or a failure to make a previous entry.

In the upper right hand of her set of cards has been stamped.

MAX. _____
MIN. _____

On this is placed the maximum number of face masks to carry and the minimum number below which the total carried is not allowed to fall.

Stock Is Built Up

As the housekeeper notes the balance, she also notices if it has fallen below the required minimum. If such is the case, she encircles the word "make" on Form 2 with a red pencil and writes below the number to be made. She then turns this form over to the sewing room as its requisition to build that particular stock up to the maximum of 300.

By looking at the tag, Form 1, we will note that on February 13, masks had fallen to ninety-six, at which time the order for making new masks was given the sewing room.

Through this system, it is possible to have always on hand at least 100 masks from which a requisition can be filled without waiting to make up a new lot, since 100 is the largest amount usually called for by any department. It is then possible to do the rebuilding of the stock in the next two or three days as other work permits. Replacements of small numbers of discarded masks can be made from the stock without stopping in the midst of some other task.

The same system is carried out in the closet containing the supply of reserve linen for the linen room. Sheets, bath towels and all other linens are stacked, tagged and all

Masks, Face		
Date	On Hand	Dept.
11/15/37	301	
11/18/37	— 85	OR
	216	
1/25/38	—100	MPC
	116	
2/9/38	— 10	OR
	106	
2/12/38	— 6	MPC
	100	
2/13/38	— 4	OR
	96	
2/16/38	204	Sewing Room
	300	

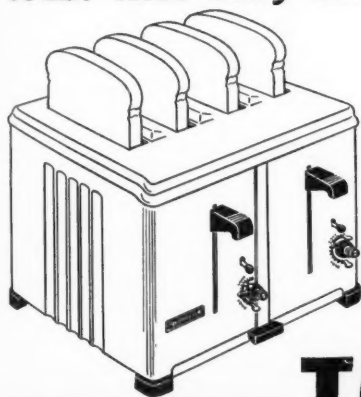
Form 1

**GIVE THEM
THE TOAST
THEY GET
AT HOME!**

TOASTMASTER Toaster

in millions of homes has
made ONE kind of toast a
national habit . . . preferred by
your patients . . . welcomed as a
friend from home! So give them the
same golden-crisp (*and more economical!*)
toast that only the New TOASTMASTER

Toaster can make!



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DEPT. J4, ELGIN, ILLINOIS



Made in 2, 3, 4
and 6-Slice Units

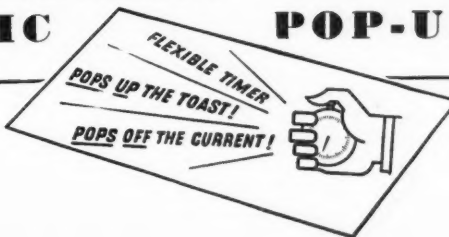
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UNIT

Max. _____
Min. _____

RECEIVED		USED			BAL. ON HAND	USED			BAL. ON HAND
Date	Quantity	Date	Dept.	Quantity		Date	Dept.	Quantity	

Form 3, Housekeeper's Master Card

transactions noted as previously described.

The housekeeper with the master cards before her and maximums and minimums plainly marked on them can plan her buying of linen so as to keep the proper supply on hand at all times to cover the needs of the linen room, as well as the replacement of linen.

The advantages of this system are:

1. The number of articles of any kind in the closet is easily determined by consulting the master cards on the housekeeper's desk.

2. At any time a glance at the tags or cards will show which departments are using a particular item, how many are called for at a time and how many have been withdrawn by any department within a given time. This forms a basis for revision of maximums and minimums.

3. Each entry furnishes opportunity of checking supplies on hand; an easy means of requesting new material from the sewing room or reminding oneself of the needs for purchasing new supplies, if articles are those that must be bought.

THE HOUSEKEEPER'S CORNER

• Dates for the fifth annual congress of the National Executive Housekeepers Association in Washington, D. C., have been changed to June 2 to 5, instead of May as had been previously planned. Headquarters for the convention will be the Hotel Raleigh.

• Starching walls may sound fantastic, yet it is a satisfactory way to provide a protective film that catches soot and dirt and can be removed easily with a minimum of injury to the wall itself. It is particularly good for stippled walls and for delicate or expensive jobs of painting. The committee on the care of walls and floors of the American Hospital Association suggests a formula for the starch as follows: One-eighth pound of cornstarch to each 2 quarts of cold water, then 2½ gallons of hot water added, mixing thoroughly. Boil twenty minutes, stirring constantly to avoid scorching. When cold apply with a calcimine brush.

• "A small surgery used chiefly for tonsil and adenoid operations had to be painted at least twice yearly, as a result of the walls being splashed with cyanide solution from the hands of surgeons and nurses", writes Jessie M. Candlish, R.N., superintendent of the Henrietta Egleson Hospital for Children, Atlanta, Ga.

"Our veteran painter made a suggestion", Miss Candlish continues, "which saved us \$25 per year in the care of the walls in this room."

"A sheet of plate glass, costing \$10, is fastened to the wall back of the basin stand holding the cyanide solution. The glass is wiped off after each operation and the walls of the room remain unstained. They are now painted all over only as often as needed or about the same as for other rooms."

"We use a folded towel to protect the glass from being knocked by the basin stand. The glass is fastened to the wall with screws and thus can easily be removed when painting the room."

• An effective means of accomplishing the work in the different sections of the housekeeping department is to have a written schedule for each employe and for each day's work nailed in a convenient place, reports Louise Leturc, housekeeper at the Bronx Hospital Nurses' home, New York.

• Many hospitals have a regular schedule for dusting walls and ceilings in the business offices and lobbies between washings. In one large hospital the equipment found to be most satisfactory is a special wall brush or a special sanitary duster resembling a floor brush in shape and having an extension handle and an extremely soft floor brush made of bristle and horse hair. Either of these tools will remove dust from the walls with a minimum of streaking.

The side walls of a room should be dusted from the top down, lapping the brush strokes in order to get complete coverage. Ceilings should be dusted first crosswise and then lengthwise of the room.

• Wall washing records provide an accurate means of checking up on the maintenance costs of rooms and the wearing quality of the paint. They also enable the housekeeper to determine whether or not some rooms are being painted or washed too often and whether the workers are efficient. The record should include the brand of paint used, the amount and cost, together with the cost in time and labor and the number of washings the paint was given before repainting was required.

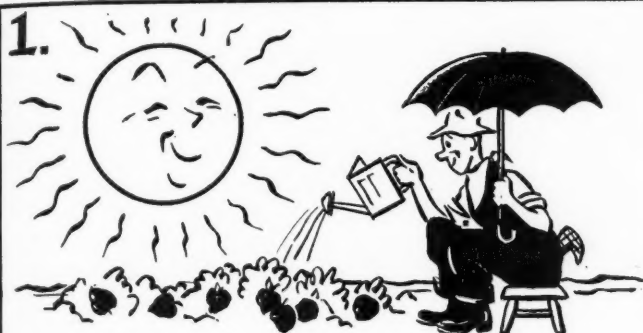
• In rooms in which woodwork or floors are being refinished and oxalic acid solution is used to restore the natural color to the wood, several housekeepers report that the solution works twice as fast if the oxalic acid solution is dissolved in hot water and applied to the wood while hot.

• A routine method for painting furniture that is approved by many housekeepers starts with careful sandpapering. Holes should be filled with plastic wood filler. The next step is to give the article two coats of thin shellac to fill the pores. Allow ten to fifteen minutes for the shellac to dry between coats and one-half hour for the last one. Apply one coat of flat white paint, giving time to dry before going over the article lightly with sandpaper and dusting off. The article is now ready for a coat of enamel paint in the color desired. When this is dry, apply a second coat if you wish more body to the color.



STRAWBERRIES

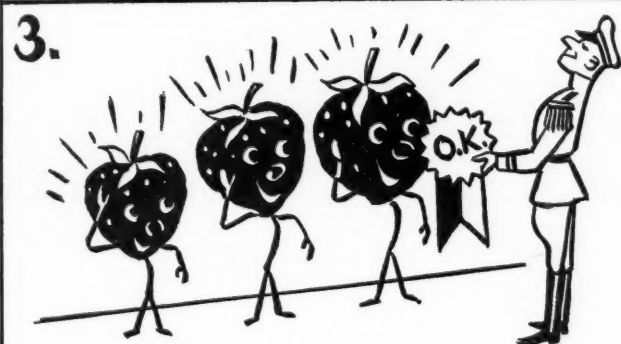
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to your kitchen*



BIRDS EYE STRAWBERRIES...famous Missionary and Marshall varieties, grown in special parts of the country where the sun and soil make strawberries grow sweeter . . . plumper . . . with a rare flavor all their own!



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Food for Child Patients

EVA NORDBY YLVISAKER

A CHILDREN'S hospital serves a special group and because of this all services connected with it are specialized. This is particularly true of the dietary department, because improper feeding and malnutrition are directly or indirectly responsible for the admission into a children's hospital of many of the patients.

Many of these children, because of lack of money or knowledge on the part of the parents, have never had adequate diets and many have never been taught to eat the foods essential to growth and development.

Thus the dietary department, as related to the patient and the staff, serves both functionally and educationally at all times.

In the Children's Hospital, Cincinnati, the daily menus are classified as general, soft and infant. A balanced diet (approximately 50 per cent carbohydrate, 15 per cent protein and 35 per cent fat) of simple wholesome, attractive foods rich in minerals and vitamins is incorporated in each day's menu.



After the cereal the milk is sipped slowly.

A typical day's general menu includes: breakfast—apricots, cooked cereal, buttered toast, jelly and milk; dinner—beef balls with gravy, mashed potatoes, buttered spinach, orange pudding, bread and butter and milk; supper—vegetable soup, wafers, scrambled eggs, peanut butter sandwich on whole wheat bread, baked apple and milk.

These children enjoy learning how the body uses various foods and love to help work out their own special diets under the direction of the dietitian.

The soft diet is the same except that apricot purée is substituted for apricots at breakfast; gravy, instead of the meat dish, spinach purée and soft custard instead of buttered spinach and orange pudding at dinner; strained vegetable soup replaces the soup course at supper and bread and butter and applesauce are given instead of the sandwich and baked apple.

The infants' menu is the same as the soft menu, with the exception that mashed vegetables replace the meat gravy at dinner and zwieback is served instead of bread and butter. Nourishments are given at 10 a.m., 2 p.m. and 8 p.m.

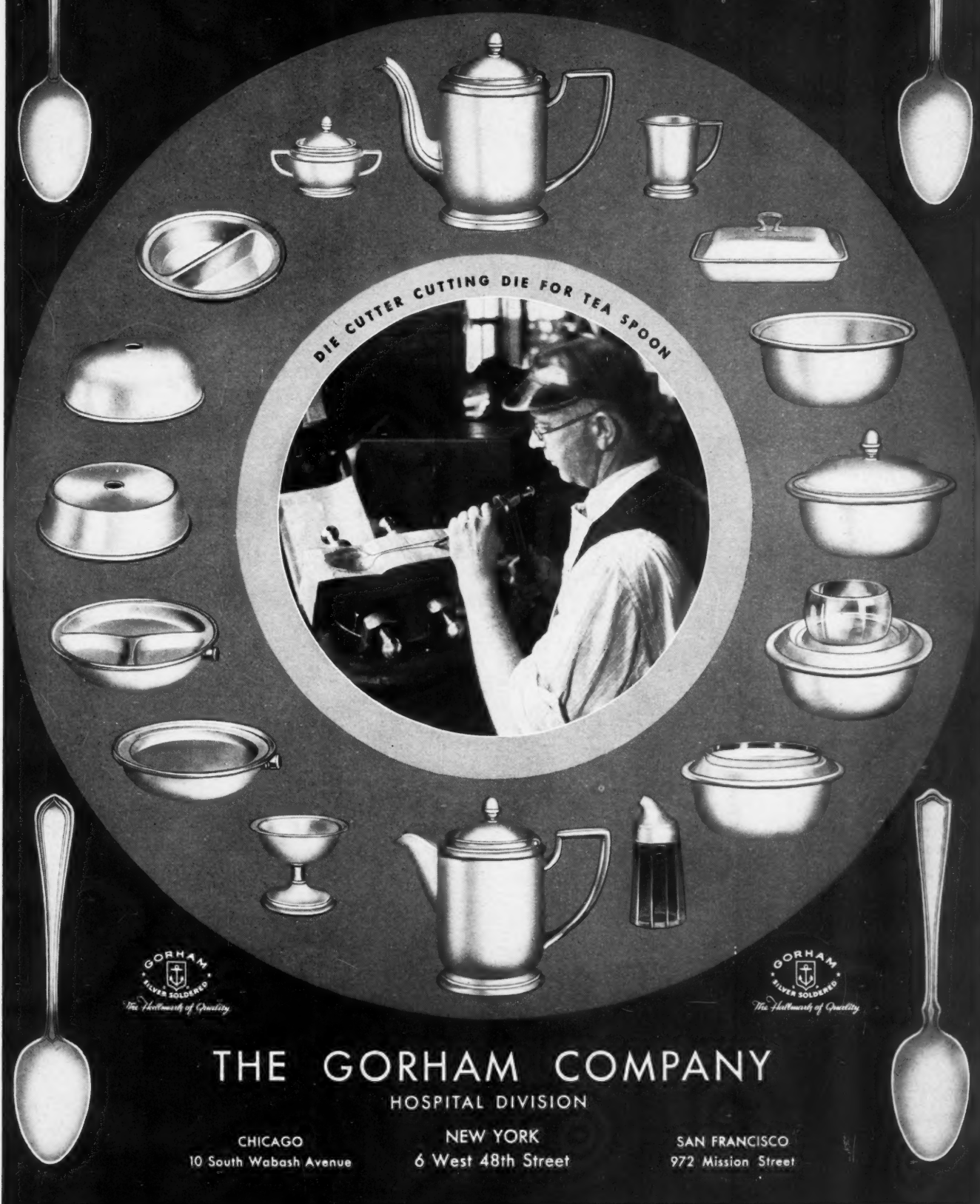
By modifying the size of the portions and consistency of certain foods, the menu described provides for all ages and conditions except the children for whom special diets are ordered. A tabulation of the food served on a day's menu, selected at random, approximately met the requirements for the various ages. The children ranged from 1 to 5 years of age. The percentage of special diets in a children's hospital is usually low.

Whenever a special diet is necessary, effort is made to approach the

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Developing good eating habits is part of the program. The dessert does not appear until the other food has been eaten. Children are encouraged to eat slowly.

normal as nearly as possible. This not only simplifies the work in the special diet kitchen, but has a good psychologic effect upon the child's future eating habits.

The trays are served attractively but simply, in order not to detract from the food itself. Children like familiar foods and, unlike many adults, children like repetition, just as they like the repetition of familiar fairy tales. Too many strange foods in the midst of strange surroundings baffle the young child and often prevent his eating at all. Thus it is important to serve those foods that a child should eat in similar garb and familiar settings, so that the child will delight in recognizing an old friend.

We withhold the dessert from the tray until the rest of the meal has been eaten, for too often the dessert is the all important thing in the eyes of the child and detracts from all other foods if served on the tray.

Many of our patients spend weeks and months with us. We attempt to aid in the formation of correct eating habits by placing adequate diets before them and for those who are able to be gathered together we hold classes under the direction of the dietitian. In these classes, in a most simple manner by the use of scissors, crayons, games and foods for demonstration, we present the essentials of a normal diet.

We have just taken our first series of motion pictures showing two of



Formulas for infants are prepared with the utmost care and are stored in refrigerator units until needed. Note the racks for storing the sterilized, capped bottles.

these classes in progress. One is a lesson on the vegetables and their value and place in the diet and the other is on the importance of milk in the diet of the growing child. The children delight not only in recognizing these foods in various forms, but also in learning of their use in the body.

The child and the parent of the child on a therapeutic diet receive instruction similar to that given by most hospitals. In the past few months our attention has been directed to mothers of the children attending the out-patient clinic.

An educational program in normal nutrition has been developed which includes the following groups employed in the hospital: student nurses from affiliated nursing schools, student dietitians from approved affiliated dietetic courses, graduate nurses and resident doctors.

The unit course is presented by members of the nursing, child care and development, and dietary departments, under the heading "Growth and Development." A general outline of this course might make for a better understanding of this aspect of the educational programs. Its twelve divisions include:

1. Introduction to Growth and Development.
2. Growth and Development During Infancy.
3. Nutrition During Infancy.
4. Mental Development in Infancy.

5. Growth and Development During the Preschool Period.

6. Nutrition During the Preschool Period.

7. Nutrition of the Older Child.

8. Growth and Development of the Older Child.

9. Mental Development of the Older Child.

10. Growth and Development of the Adolescent.

11. Mental Development of the Adolescent.

12. Malnutrition.

In this manner the entire picture of the child's development is ac-

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KNOX Gelatine goes a longer way because of its *greater jelling strength*.

Do this if you want to make certain of this economy factor — Take one ounce of Knox Gelatine and make a jelly of it. You will have *four pints* of uniform, firm jelly. Now, try to make this quantity and quality of jelly with other gelatines. In most cases, the result will be either a flabby, unpalatable product or no jelling at all.

St-r-e-t-c-h your gelatine dollar by ordering Knox Sparkling Gelatine. Every batch of Knox Gelatine is scientifically tested for jelling and viscosity strengths. It costs approximately the same as inferior products.



. . . WHY you should **INSIST** on **KNOX SPARKLING GELATINE**

Because Knox Gelatine is 85% protein in an easily digestible form — because it contains absolutely no sugar or other substances to cause gas or fermentation, Knox Gelatine should not be confused with factory-flavored, sugar-laden dessert powders. Knox is 100% pure U.S.P. gelatine. Knox Gelatine has been successfully used in the dietary of convalescents, anorexic, tubercular, diabetic, colitic, and aged patients.

Knox Gelatine in 1 lb. Institutional packages may be ordered through any grocery jobber. Also Knox Jell (flavored gelatine dessert in 6 pure fruit flavors) packed 26 oz. and 10 lb. tins.



Useful Dietary Booklets On Request. Write Dept. 465

KNOX SPARKLING GELATINE
IS PURE GELATINE — NO SUGAR

KNOX GELATINE LABORATORIES, Johnstown, N. Y.

quired by the student. This outline is used in teaching graduate and undergraduate nurses and part of it is used for the student dietitians and the resident medical staff.

The student dietitian coming to Children's Hospital becomes acquainted with the various age groups by means of lectures, semiweekly

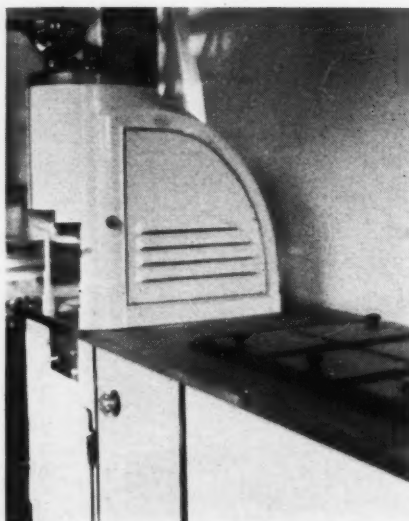
medical bedside clinics on nutritional diseases, out-patient clinics and also through planning menus and preparing infant feedings that meet the nutritional needs. By careful observation and study of food preparation and service, she sees the function of the dietary department in the care of the sick child.

Equipped for Service

ALTA HIRSCH

DEVELOPMENTS in the dietary department at Miami Valley Hospital, Dayton, Ohio, have brought pleasing comments during the last six months; they are due primarily to the installation of new equipment. New ranges and an individually controlled two-deck baker's oven were installed and a unit for freezing and storing ice cream was established in a section of the main kitchen.

Knowledge of the volume of the baker's products is enlightening. Parker house or cloverleaf rolls,



The ice cream unit, above, has a 5-gallon freezer and a 60-gallon hardening cabinet, with a 20-gallon storage compartment for mix. The individually controlled, two-deck baker's oven, left, makes it possible for the baker to turn out 200 dozen Parker house rolls per week. In addition pastries and cakes are baked.



made daily, total 200 dozen per week. Sweet rolls are also used daily and total about 50 dozen per week.

Add to these 150 pies and 2000 servings of assorted cakes and cookies, besides 30 dozen muffins, biscuits or doughnuts. Meringues, lady fingers and jelly rolls, puff pastry and other more complex dainties are made in addition to steamed and baked puddings, cornbread and nut

or fruit breads. Bread is the only bakery item that we do not produce at the present time.

Increased production possibilities allow each group within the hospital to enjoy more variety in desserts. The frozen dessert may be used more frequently since the cost is now only 40 per cent of the former price.

Groups finding occasion to meet periodically within the hospital have

requested special cakes at cost. It has been a satisfaction to feel that fulfilling such requests is not unreasonably overtaxing the department.

It has been customary to provide aid for the experienced baker. A maid who was interested in learning how to make desserts was trained to be his helper. In time she learned to make all of the starch puddings, custards, whips, gelatin desserts, dessert sauces and sauces for ice cream.

This dessert cook also makes about 800 gallons of frozen desserts a month. In addition to the freezing process itself she prepares sherbet mixes, fruit, nuts, candy and foundation flavors for ice cream and all toppings. She is responsible for the entire unit, including distribution of ice cream and cleanliness of the equipment, all of which requires about one half of her work day.

Special ice cream preparations are not used, since we prefer fresh or frozen fruits. In many cases canned fruit in the crushed or puréed form is used. An example of the latter is a product like fresh peach ice cream produced from peach purée or apricot purée. Fruits bought in the usual No. 10 size rather than in the sizes put up especially for a certain sized freezer provide a less expensive and more pleasing product.

Sherbets are made with fresh fruit juices when they are available. Orange and lemon are always popular. An orange vitamin C beverage powder provides an inexpensive orange sherbet when the powder is combined with fresh orange juice.

The fact that the main kitchen is of two-story height necessitated enclosing the ice cream unit with a screen ceiling and adding two walls. A window in each of the outside walls places the operations in full view of passers-by. The room itself is 13 by 9 by 9½ feet.

Equipment of the ice cream unit includes a 5-gallon freezer in connection with a 60-gallon hardening cabinet and a 20-gallon storage compartment for mix, two metal cabinets to store scales, thermometer, ladles, measures, linen, supplies, extracts and parchment paper, an enamel top table and a smaller movable table.

The only other equipment is concerned with transportation and service of ice cream. Cans of 2½-gallon capacity were chosen to enable the

(Continued on page 100.)

LIBBY'S PEACHES . . . HALVES SUPERBLY MATCHED!

FOR THE HIGH VITAMIN DIET

Here's a quick and clever salad that's high in vitamins, tempting to look at and to taste. Libby's California Peaches are the makings of it . . . with them, thrifty cabbage on a bed of watercress. • Often, as here, you serve peach halves in couples, so you'll find it's always wise to choose peaches packed by Libby. For Libby's Peaches are superbly matched for size, shape, texture, color. They're *nicer* . . . and why not always serve them when they cost you no more than ordinary kinds? • Try this salad soon, for High Vitamin Diets as well as for the staff and general menus. It's quickly prepared, moderate in price, and unusually delicious. The flavor of the watercress and cabbage combines perfectly with the mellow, full-ripe lusciousness of Libby's California Peaches.

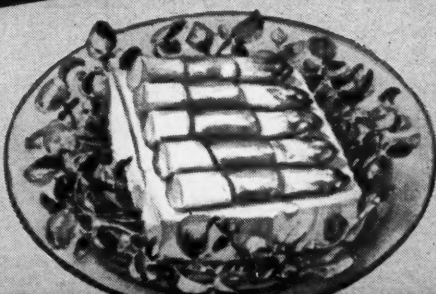
Have you tasted Libby's?

100 Fine Foods, including Fruits and Fruit Juices, Tomato Juice, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, and Alaska Salmon. Each comes in regular and special sizes for institutions. In addition, Libby packs Homogenized Foods for Babies.



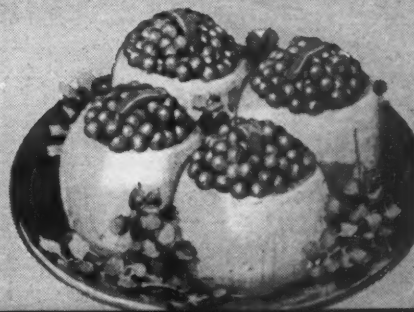
FOR THE BLAND DIET

Make a loaf of cottage cheese stiffened with gelatin. Slice, and serve topped with Libby's Asparagus Tips. Like Libby's Peas, the Asparagus is *quick-canned* for tenderness, flavor, and full nutritional value. Try Libby's California Asparagus—both Tips and Stalks. You'll taste the difference.



FOR THE GENERAL DIET

"Something different" to perk up patients' appetites and please the staff—Libby's Peas in hollowed-out, parboiled onions. You'll find Libby's Peas are unusually tender and savory. That's because they're *quick-canned*—hurried from gardens to kitchens often in less than an hour.



Lenten Dish



Tomato filled with corn creole gratin: Mix short peg corn with a stiff well-seasoned creole sauce and sprinkle with grated cheese, bread crumbs and dot with butter. Brown in a hot oven and serve at once.—*Arnold Shircliffe, Chicago.*

Private Patient's Tray



Private patients' trays are served in this attractive manner at University Hospitals, Cleveland, Ohio.—*Marie L. Hines, director of dietetics.*



(Continued from page 98.)

girl to handle them without aid. Flat lids are used to advantage in storage as they permit stacking.

To eliminate the necessity for a tempering cabinet, insulated carry-out bags of canvas are used. The ice cream becomes sufficiently tempered to serve when allowed to remain in these canvas bags for about five hours in winter. This time span is shortened during the summer.

The refrigerated serving cabinets used in two major kitchens also serve to temper the extremely hard ice cream, provided the ice cream remains in them as long as twenty-four hours before service. These cabinets and cans are used for serving chilled desserts or frozen fruit salad. The cabinets are fashioned into one compartment 21 by 26 inches so that they may be put to additional use. Flat pans or trays may be conveniently stacked in them, thereby permitting the chilling of sherbet cups and the like.

Four, 3-foot gas ranges, thermostatically controlled, have permitted roasting of meats at low temperature. The tops of these ranges are used constantly. Because of more controlled cooking space, more variety and smaller quantity cooking are possible.

Accessory equipment recently added to the baking unit is a 10-quart mixer that may be used for whipping eggs, cream or icings simultaneously with the large mixer. We prefer it, for this reason, to a small attachment for the large mixer. Since the mixer has been placed on a movable cabinet having ample closed storage space beneath, it is more convenient to use. The baker also finds the all-metal movable cooling rack to be serviceable. It is equipped with twenty-six 22 by 26-inch removable galvanized shelves.

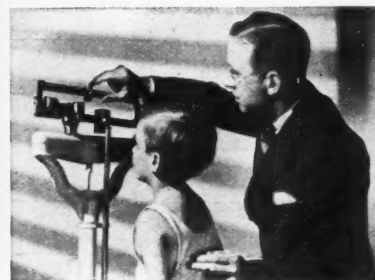
Two all-metal pot and pan racks each provide three 7 by 1-foot shelves and two 7 by 3-foot shelves. The shelves are of galvanized bar iron. These racks, which may be easily moved, have eliminated many problems. They hold all of the main kitchen utensils, baking pans and storage containers compactly. Vertical bars, which support the shelves both in the center and on the ends, serve a double purpose since they are perforated to hold hooks on which additional utensils may be hung.



Many physicians today are recommending a diet fortified with protective foods for underweight children. Diets believed to be adequate are often deficient in some important respect.



Lack of appetite is often one of the early manifestations of a defective diet. Correction of the defect may quickly show an improvement in appetite.



Faulty nutrition is a common cause of underweight in children. The addition of Ovaltine to the usual diet intrigues the taste as extra values are added.

Anorexia, Failure to Gain in Weight...

and Corollary Problems may be due to Deficiencies in Diet

Symptoms of mild, subclinical dietary deficiencies in children are fairly common even among "well-fed" groups. Diets thought to be adequate, many times are deficient or lacking in some essential factor.

Many physicians today are finding that fortifying the diet with protective foods often brings beneficial results. More and more, they are turning to Ovaltine as a food supplement. For Ovaltine supplies valuable protective food elements in a delicious liquid form.

Ovaltine contains a variety of protective food factors. It supplies vitamins A, B₁, B₂ and D, and the minerals calcium, phosphorus, copper and iron. (See table.)

Not only does Ovaltine increase the consumption of milk, but it makes milk a more digestible, more palatable and more valuable food. For example, Ovaltine provides 120

U.S.P. units of vitamin D in each serving, a factor in which ordinary milk is frequently low.

Best of all, Ovaltine is economical. A single serving for only 2½ cents is a remarkably low cost for such high food value.

Try Ovaltine with your child patients who are underweight. It is a pleasant and valuable method of fortifying the diet that children will quickly approve.

OVALTINE CONTAINS THESE PROTECTIVE FOOD ELEMENTS:

Vitamin A	Calcium
Vitamin B ₁	Phosphorus
Vitamin B ₂	Copper
Vitamin D	Iron

OVALTINE

FOR THE GROWING CHILD



Copyright 1938, The Wander Company

May Dinner Menus for the Small Hospital

Evelyn Hailey

Dietitian, Mary Lanning Hospital, Hastings, Nebr.

Day	Soup or Appetizer	Meat	Potatoes	Vegetable	Salad or Relish	Dessert
1.	Tomato Juice	Fricassee Chicken	Mashed Potatoes	Buttered Carrots	Pineapple-Apricot-Date Salad	Butterscotch Sundae
2.	Broth With Noodles	Meat Loaf, Tomato Sauce	Browned Potatoes	Fresh Green Beans With Bacon	Sectioned Orange-Grapefruit Salad	Tapioca Cream With Chocolate Sauce
3.	Fresh Fruit Cocktail	Roast Beef	Mashed Potatoes	Harvard Beets	Asparagus and Cream Cheese Salad, French Dressing	Orange Cornstarch Pudding
4.	Turkish Soup	Lamb Chops, Pine-Mint Preserves	Creamed New Potatoes	Buttered Fresh Peas and Diced Carrots	Frozen Fruit Salad	Cup Cakes With Lemon Sauce
5.	Broth With Rice And Celery	Swiss Steak	Riced Potatoes	Buttered Whole Wax Beans	Tomato Aspic	Pineapple Upside-Down Cake
6.	Consommé	Baked Halibut, Tomato Sauce	Buttered Diced Parsley Potatoes	Buttered Fresh Green Limas	Pickled Beet Salad	Caramel Ice Cream
7.	Vegetable Soup	Ground Veal Patties	Escalloped Potatoes	Buttered Fresh Spinach With Cream	Stuffed Tomato Salad	Pineapple Snow
8.	Grapefruit-Strawberry Cocktail	Roast Lamb With Currant Jelly	Mashed Potatoes	Creamed Fresh Peas	Lettuce, Thousand Island Dressing	Chocolate Sundae
9.	Alphabet Soup	Baked Ham	Baked Potatoes	Fresh Asparagus With Buttered Bread Crumbs	Spring Salad	Blackberry Cobbler
10.	Noodle Soup	Smothered Chicken	Mashed Potatoes	Baked Eggplant	Fresh Fruit Salad	Maple Sponge
11.	Tomato Juice	Braised Veal Round Steak	Mashed Sweet Potatoes (Canned)	Creamed Wax Beans	Celery-Carrot-Raisin Salad	Fresh Strawberry Tarts
12.	Cream of Pea Soup	Roast Beef	Mashed Potatoes	Buttered Summer Squash	Tomato-Asparagus Salad, French Dressing	Apricot Ice Cream
13.	Fresh Fruit Cocktail	Perch Filet, Lemon Sauce	Au Gratin Potatoes	Stewed Tomatoes	Cabbage Salad	Graham Cracker Pudding
14.	Cream of Celery Soup	Ham Loaf	Hashed Brown Potatoes	Roasting Ears (Canned)	Perfection Salad	Grape Sherbet
15.	Pineapple Juice	Braised Beef Tenderloin Steaks, Mushroom Sauce	Mashed Potatoes	Creamed Cauliflower	Tomato-Green Pepper Salad	Chocolate Almond Ice Cream
16.	Tomato Bouillon	Beef Stew With Vegetables	Boiled Potatoes	Spinach With Bacon	Spiced Apricots	Baked Prune Whip
17.	Cream of Asparagus Soup	Lamb Steaks	Baked Potatoes	Creamed Fresh Peas	Lettuce, Russian Dressing	Strawberry Shortcake
18.	Broth With Okra and Tomato Juice	Meat Loaf	Creamed Whole Potatoes	Fresh Green Beans	Fruit Salad	Grapenut Pudding
19.	Orange Juice	Veal Cutlets	Mashed Potatoes	Baked Summer Squash	Endive, French Dressing	Bavarian Cream
20.	Cream of Spinach Soup	Baked Halibut, Tartare Sauce	Escalloped Potatoes	Buttered Fresh Asparagus	Jellied Carrot-Pineapple Salad	Peppermint Ice Cream
21.	Apricot Nectar	Roast Beef	Mashed Potatoes	Buttered Brussels Sprouts	Beet-Hard Boiled Egg Salad	Peach Tapioca
22.	Chicken Broth With Rice	Mock Chicken Legs	Creamed Diced New Potatoes With Parsley	Buttered Fresh Spinach	Tomato Aspic With Stuffed Olives	Angel Food Cake, Fresh Strawberry Ice Cream
23.	Consommé	Roast Lamb, Mint Jelly	Hashed White Potatoes	Creamed Carrots	Spiced Apricots	Tutti-Frutti Ice Cream
24.	Tomato Juice	Baked Ham	Browned Potatoes	Broccoli With Cream	Pineapple-Celery-Date Salad	Marshmallow Pudding
25.	Noodle Soup	Veal Stew	Mashed Potatoes	Stewed Tomatoes	Spiced Grapes	Custard With Whipped Cream
26.	Broth With Celery	Roast Beef	Buttered Diced Potatoes	Buttered Fresh Beets	Head Lettuce, Thousand Island Dressing	Vanilla Ice Cream
27.	Split Pea Soup	Salmon Croquettes, White Sauce	Browned Potatoes	Creamed Celery and Carrots	Tomato and Cottage Cheese Salad	Apricot Whip
28.	Broth	Baked Steak	Riced Potatoes	Tomatoes and Okra	Fruit Salad	Jelly Roll With Whipped Cream
29.	Fresh Fruit Cocktail	Fried Chicken	Mashed Potatoes	Creamed Fresh Asparagus	Spring Vegetable Salad, French Dressing	Chocolate Ice Cream
30.	Julienne Soup	Beef Patties	Escalloped Potatoes	Baked Eggplant	Spiced Pears	Strawberry Shortcake
31.	Orange Juice	Roast Veal	Mashed Potatoes	Creamed Peas and Carrots	Cabbage Salad	Fresh Cherry Tarts

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

WHY SO MANY DIETITIANS PREFER

Ralston Wheat Cereal

IT COOKS IN 5 MINUTES

IT'S $2\frac{1}{2}$

TIMES RICHER IN
VITAMIN B THAN NAT-
URAL WHOLE WHEAT!



Ralston Cooks Quickly—is completely digestible, thoroughly cooked in only 5 minutes over an open flame, thus providing all the advantages of a hot wheat cereal with a minimum of effort.

Supplies Abundant Vitamin B. Enriched with pure wheat germ, Ralston supplies $1\frac{1}{2}$ International units of vitamin B in each gram. Consequently each serving assures generous quantities of this vitamin so essential to normal appetite and digestion.

Appeals to Adults and Children. Made of premium whole wheat (with only coarsest bran removed) Ralston has a rich appetizing flavor that appeals to persons of all ages. This simplifies the preparation of breakfast in both home and hospital.

Costs So Little—less than 1¢ for a generous serving. Research Laboratory Report and samples of Ralston Wheat Cereal will be sent on request. Use the coupon.

RALSTON WHEAT CEREAL

RALSTON PURINA COMPANY, Dept. MH, 2155 Checkerboard Square, Saint Louis, Missouri

Without obligation, please send me samples and copies of the Research Laboratory Report.

Name _____ Address _____

City _____ State _____

(This offer limited to residents of the United States)

Monthly News Review

Vol. 50

April 1938

No. 4

Profitable Discussions and Exhibits Please New England Administrators

Hospital people in New England spent three profitable days in Boston during the month and returned to their posts with the answers to many of their problems. The occasion which brought them in large numbers to the Hub was the sixteenth annual meeting of the New England Hospital Association from March 10 to 12.

The Hotel Statler, convention headquarters, buzzed with hospital talk which started with the ambulance exhibit staged in the spacious lobby, carried upstairs to the mezzanine floor where more exhibits were lined up for inspection, into the ballroom where talks and discussions took place and even to the floors above where an overflow of exhibitors displayed their wares. Everyone conceded it the best of the New England series.

The first phase of hospital organization to be discussed logically concerned the front office. Leroy P. Cox, C.P.A., superintendent, Woonsocket Hospital, Woonsocket, R. I., was the speaker.

The office force of the small hospital is generally undermanned, Mr. Cox contends, which is unfortunate, for constant plugging away on all accounts is essential. Sometimes the services of the night switchboard operator may be enlisted in making out bills and doing other office routine. There is also some hope in boosting collections if the floor duty nurses are encouraged to help in gathering what information they can about the financial position of the patient. Doctors, too, should be asked to cooperate.

Mr. Cox advocates a series of three or four letters sent out at two-week periods and he warned that no lawsuit should be threatened unless actually carried out. A six months' analysis of costs every two years is most helpful, he has found. The maternity department will likely prove to be the most costly.

More interest centered upon a discussion of nursing problems than any other one subject, the status of the nurse's aide or ward helper starting lengthy debate. In reviewing the program of instruction for staff nurses, Laura R. Logan, R.N., director, school of nursing and nursing service, Boston City Hospital, made a plea for a working week which would

make possible time for graduate staff work and a cultural background.

"A successful staff education," she pointed out, "can be effective only under favorable working conditions and number of hours. Too often the staff nurse believes her education is over." The work of bedside nursing should be a final aim, she added, and bedside staff nursing be accorded its rightful place in the hospital. Another point she raised was the great necessity for a skilled teaching force.

Given proper training, duties which are nursing, yet not of a skilled character, are not beyond the province of a ward helper, according to Ruth Pollock, R.N., supervisor, Worcester City Hospital, Worcester, Mass. Among these are giving baths, rubbing backs and taking temperatures. Miss Pollock sees the
(Continued on page 118.)

Doctor MacEachern Is New President of I. H. A.

Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, has been elected president of the International Hospital Association to succeed Dr. G. von Deschwenden of Lucerne, Switzerland, who has resigned because of ill health. Doctor MacEachern has been a vice president of the association for several years and has been active in I.H.A. affairs. This elevation to the presidency doubtless means that Doctor MacEachern will preside at the next congress of the association, which is scheduled to be held in Toronto in 1939.

Campaign for 130-Bed Hospital

The Homeopathic Medical and Surgical Hospital, Reading, Pa., has started a campaign for \$535,000 with which to build a new 130-bed hospital, according to Olin L. Evans, superintendent.

Issues in Hospital Administration Flare Up at San Francisco Meeting

Smoldering issues of hospital administration—colonies for alcoholics and epileptics, diversion of a portion of gasoline taxes to smaller hospitals lacking public support as a result of the increase in highway automobile accidents, drastic police action against highway accident and other patients who flee their hospital bills, a proper public comprehension of venereal disease—burst into flame at the twelfth annual convention of the Association of Western Hospitals meeting in San Francisco, February 28 to March 3.

Meeting concurrently and jointly were the Western conference of the Catholic Hospital Association and the Association of California Hospitals.

Old issues also were aggressively pushed—group insurance, opposition to opening of tax-supported sanatoriums to all classes and the establishment of preferred cost schedules for powerful corporations, groups and individuals.

The choice of Harold S. Barnes, administrator of the Latter Day Saints Hospital, Salt Lake City, as president-elect of the association, and the forthcoming term of A. C. Jensen, incoming

president, who is superintendent of the Fairmont Hospital, Oakland, Calif., give assurance of aggressive progress.

Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, struck a responsive note in speaking in the first day session that resounded throughout the convention.

"The hospital administrator must assure every person in the community competent, scientific care through having an institution so set up that it can guarantee such treatment," Doctor MacEachern said. "The hospital administrator must see that every man, woman and child coming to its doors, regardless of race, color, creed or social status, secures proper medical care."

Robert E. Neff, president of the American Hospital Association, pointed out that hospitals are taking care of the wealthy on one hand and the indigents on the other, but that the middle class is being neglected in this particular. "Group hospitalization provides this care for the white collar class. It paves the way for equitable service to all classes of society, and makes finances a secondary consideration."

THE CRUCIAL TEST—Laboratory tests are not always decisive. Clinical trial is essential really to prove the merit of new drugs. The Lilly trade-mark on pharmaceuticals and biologicals is assurance of conscientious testing both in the clinic and in the laboratory.



'SODIUM AMYTAL' (Sodium Iso-amyl Ethyl Barbiturate, Lilly) has become the standard for comparison among hypnotics. Probably no barbiturate has had more extensive clinical trial and none has emerged from years of therapeutic use with a more enviable record for dependability and safety. » Supplied in pulvules (filled capsules) and in ampoules. Parenteral injection should be restricted to convulsive conditions.

ELI LILLY AND COMPANY

INDIANAPOLIS, INDIANA, U. S. A.

Three Themes Selected by Tri-State Assembly for Program at Chicago

Hospital personnel problems, maternal and infant care in hospitals and present problems of nursing service are the three themes selected for special attention at the Tri-State Hospital Assembly, at the Hotel Stevens, Chicago, May 4 to 6. States represented are Illinois, Wisconsin and Indiana.

Nineteen participating organizations and sections, representing as many phases of hospital service, will hold group conferences on Wednesday and Thursday afternoons. The annual banquet will be held on Thursday night with a program especially built for appeal to hospital trustees.

The largest exhibit in the history of the Tri-State is being arranged by Albert G. Hahn, executive secretary.

Speakers on personnel problems include Dr. Arthur C. Bachmeyer, University of Chicago Clinics; Dr. Arnold F. Emch, executive director, Chicago Hospital Council; Dr. John E. Gorrell, Blodgett Memorial Hospital, Grand Rapids; Edgar Blake, Methodist Episcopal Hospital, Gary, Ind.; Joseph G. Norby, Columbia Hospital, Milwaukee; Mabel Binner, Children's Memorial Hospital, Chicago; Herman Hensel, Presbyterian Hospital, Chicago, and Alden B. Mills, *The Modern Hospital*, Chicago.

At the Thursday morning session on maternal and infant welfare speakers include Dr. Fred L. Adair, University of Chicago; Dr. William C. Danforth, Evanston Hospital; Dr. William H. Walsh, Chicago; Rev. Herman L. Fritschel, Milwaukee Hospital; Dr. Frederick H. Falls, University of Illinois College of Medicine; Dr. Charles W. Myers, Indianapolis City Hospital; J. Dewey Lutes, Ravenswood Hospital, Chicago; Dr. R. C. Buerki, State of Wisconsin General Hospital; Dr. Edward L. Cornell, Northwestern University Medical School; Dr. M. Edward Davis, University of Chicago; L. C. Vonder Heide, West Suburban Hospital, Oak Park, Ill., and Dr. Thomas R. Ponton, *Hospital Management*, Chicago.

The program for the nursing section is not yet complete but it will include a discussion of the present status of nursing service and nursing education by national leaders. Dr. Bert W. Caldwell, editor, *Hospitals*, will summarize the discussion.

Several new sections will convene with the Tri-State Assembly this year, including hospital pharmacists, clinical

pathologists, bacteriologists, radiological technicians and physical therapists. The usual sections for dietitians, nurses, accountants, housekeepers and similar groups will be held. A special round table conference for small hospitals will be held on Friday afternoon under the chairmanship of Gladys Brandt, Cass County Hospital, Logansport, Ind.

Midwest Administrators Will Meet in Kansas City for Annual Convention

Hospital administrators from five states—Arkansas, Colorado, Kansas, Missouri and Oklahoma—will gather for the Midwest Hospital Association convention in Kansas City, Mo., April 21 to 22.

Following greetings by President T. J. McGinty of the Midwest Hospital Association and the addresses of welcome by Dr. Edwin H. Schorer, health director, Kansas City, Mo., and L. C. Austin, president of the Missouri Hospital Association, the convention will hear the business manager of the University of Colorado School of Medicine and Hospitals, William S. McNary, discuss "Sportsmanship in Hospital Buying."

Alden B. Mills, managing editor, *The Modern Hospital*, will speak at the luncheon meeting for hospital trustees and members of the Midwest association, at which Lee C. Gammill, superintendent of the Baptist State Hospital, Little Rock, Ark., will preside. Mr. Mills will direct his message to the trustees. His subject will be "In the Trustee Lies Our Strength."

The afternoon session following the luncheon will be devoted to the consideration of hospital care insurance and of nursing education standards. Following an address by Dr. C. Rufus Rorem, director of the commission on hospital service of the A. H. A., on hospital care insurance, Ray F. McCarthy, executive director, Group Hospital Service, Inc., of St. Louis, will lead the discussion.

Henrietta Froehlke, R.N., director of the department of nursing, University of Kansas, will speak on the subject, "Can the Educational Standards, as Recently Adopted by the National League of Nursing Education, Be Instituted in the Majority of Nursing Schools?" The session will close with a round table discussion on accounting

conducted by Doctor Rorem. Dr. E. T. Olsen, president-elect of the Midwest association, will preside at this meeting.

At the morning session on April 22 Arden E. Hardgrove, formerly of the A. H. A., will conduct a round table session on hospital legislation.

Walter J. Grolton, superintendent of City Hospital No. 1, St. Louis, will preside at the closing session on Friday afternoon, at which Myron Green, cafeteria company president of Kansas City, Mo., will discuss the curtailment of food waste; Dr. T. R. Ponton, Chicago, medical records, and Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, will lead a round table discussion.

Kentucky Hospital Association Holds Live Meeting on March 8

More than 100 hospital administrators and department heads gathered for the annual meeting of the Kentucky Hospital Association in Louisville on March 8. Arden E. Hardgrove, former assistant executive secretary of the A. H. A. and new administrator of the John N. Norton Memorial Infirmary, Louisville, was guest speaker at the luncheon and also was in charge of the round table.

H. L. Dobbs, superintendent of the Kentucky Baptist Hospital, Louisville, was reelected president of the state association, and Dr. Edward J. Murray, administrator of the Julius Marks Sanatorium, Lexington, president-elect. Sister Alacoque of Covington and Sister Celeste Maria of Lexington were named vice presidents. J. T. Wheeler, superintendent of the Pewee Valley Sanitarium and Hospital, Pewee Valley, was elected secretary-treasurer. Mr. Dobbs was chosen delegate to the A. H. A. convention.

Lutherans Purchase Hospital

The Lutheran Good Samaritan Society has purchased the Grand Island General Hospital at Grand Island, Neb., and will operate it under the name of the Lutheran Hospital. The new improved hospital will be in charge of Mrs. Emma Pursley, formerly of Minneapolis. The society operates hospitals in about ten states.

State Dietetic Meetings

Meetings of state dietetic associations have been announced as follows: Ohio at Columbus on April 5 and 6; Texas at Houston on April 22 and 23; Florida at Miami on May 9, and Louisiana at New Orleans on December 12.

BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

II. THE BLANCH

● Previously, we have described the reasons for the thorough cleansing of raw food materials prior to canning and the methods by which such cleaning is effected. Another basic operation in the commercial canning procedures for many vegetables and some fruits, is known as the "blanch". (1)

In essence, the blanch is an operation in which raw food material is immersed in warm or hot water, or exposed to live steam. The blanch serves a multiple purpose.

First, blanching serves to soften fibrous plant tissue. By so doing, it contracts or expands these tissues and thus insures a proper final fill in the tin container. Second, during the blanch, respiratory gases contained in the plant cells are liberated. This release of gas prevents strain on the can during heat-processing and favors development of a higher vacuum in the finished product.

Third, the blanching operation inhibits

enzymes naturally present in the raw foods and prevents further enzymatic action. Inhibition of enzymes—particularly those inducing oxidative reactions, yields products of superior quality and nutritive values. Fourth, the blanch may serve as an added cleansing measure and also remove "raw" flavors from certain foods. A final function of the blanching operation is to fix or set the natural color of specific products.

In commercial canning practice, blanching is usually accomplished in equipment especially designed for certain types of products. In general, the raw products after thorough washing are conveyed through water or steam by various mechanical devices capable of adjustment so as to subject the raw materials to a particular temperature for the proper period of time.

Such, in broad detail, are the purposes and mechanics of the blanch, a basic operation in many commercial canning procedures.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

(1) 1937 Appertizing or The Art of Canning,
A. W. Bitting,
The Trade Pressroom, San Francisco.

This is the thirty-fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

New Ultraviolet Sterilization Process Marks New Era in Antisepsis and Asepsis

Henry B. Zerling, M.D.

A demonstration meeting on the Rentschler-James sterilization process by ultraviolet radiation was held at the American Institute in New York on March 7. This process is designed for the sterilization of foods, surfaces, liquids and air by means of a selected portion of the ultraviolet spectrum, the technic having been developed during five years of research in the Westinghouse laboratories. Its practical application may revolutionize the control of food and air-borne diseases. Dr. F. S. Brackett, principal physicist of the U. S. Public Health Service, presided at the meeting.

Dr. Harvey C. Rentschler presented the general principles of the destruction of bacteria by ultraviolet radiation. Ultraviolet rays, especially those under

amount of radiation in a given area is measured by an ultraviolet meter based on photo-electric cells especially adapted to this light range, and the lethal ratio of time and radiation effects on bacteria colonies has been calculated. The most efficient method of ultraviolet ray production is generation by electric discharges through gases or vapors in comparison with the less economical arc apparatus. Doctor Rentschler presented a dramatic demonstration of the lethal effect of these selected rays on the screen, showing the rapid disintegration of paramoecia.

Dr. Robert F. James, biophysicist, spoke briefly on the sterilization value of this technic as applied to utensils, drinking glasses and foods. Experimental evidence indicates definitely that

cation of ultraviolet sterilization in surgery. The method has been used in 800 operations and was described in *The MODERN HOSPITAL* in June, 1936. The total reduction of wound infections on all the surgical services was from 4 per cent to 0.5 per cent. On thoracoplasties, the infections were reduced from 38.5 per cent to 3.4 per cent. The lamp was placed approximately 10 feet above the floor and it was necessary to protect skin and eyes of the operators.

It may well be that the Rentschler-James process marks a new era in antisepsis and asepsis. The evidence thus far presented seems to have been subjected to rigorous scientific control and the method is worthy of further application in the public health and hospital fields.



Performing an operation under a battery of bactericidal ultraviolet rays.

3000 Angstrom units, have the power of attenuating and killing bacteria.

The practical utilization of this principle would necessitate (1) some quantitative measure of bactericidal radiation; (2) a suitable generator at low cost, low temperature, minimum ozone production and minimum deleterious effect on the host, and (3) the elimination of undesirable side effects.

An improved technic for the estimation of bacterial content in the atmosphere of a room has been devised. The

the bacterial count on utensils can be diminished to a negligible factor. The importance of such a result is obvious in the control of epidemics such as streptococcus sore throats and Vincent's angina. An interesting application of light sterilization was observed in the study showing that foods can be preserved with less refrigeration, so as to minimize dehydration losses and thus reduce the cost of handling foods.

Dr. Deryl Hart, professor of surgery, Duke University, discussed the appli-

Philadelphia Physicians, Hospital Council Agree on Plan for Group Insurance

A hospital care insurance program for Philadelphia came nearer realization recently when the Philadelphia County Medical Society and the Philadelphia Hospital Council reached an agreement on terms.

In order to meet the physicians' objections to the inclusion of x-ray and similar services, the plan provides that the subscriber is to be indemnified for payments made by him for these services up to certain maximum amounts. In order to make the plan administratively and actuarially sound, the hospitals in turn agreed to be reimbursed at a flat rate per day and to deduct the cost of the special services from the rate decided on.

The agreement was signed and published in the Philadelphia County Medical Society's *Weekly Roster and Medical Digest* and in the *Pennsylvania Medical Journal*. Then the American Medical Association heard of it and sent representatives to Philadelphia to bring pressure to have it abrogated.

Thomas Conway Jr., president of the Philadelphia Hospital Council and chairman of the special council committee on hospital care insurance, has indicated that the plan will now go ahead anyway. The Community Fund of Philadelphia has agreed to lend the plan \$30,000 to get it started. Nominations for the first board of trustees include three hospital administrators, three representatives of the medical societies, nine hospital trustees, six of whom represent the public, and three others to be selected by the new board when it takes office.

WHEN I GOT MY FREE HOSPITAL SOAP CHART!

Simplified

AUTOMOBILES		PAINTWORKING		METAL-GENERAL	
Dashboard	1/2 lb. Soap	Body	1/2 lb. Soap	General	1/2 lb. Soap
Engine	1/2 lb. Soap	Wheels	1/2 lb. Soap	Tray	1/2 lb. Soap
Interior	1/2 lb. Soap	Windows	1/2 lb. Soap	Walls	1/2 lb. Soap
Exterior	1/2 lb. Soap	Doors	1/2 lb. Soap	Floors	1/2 lb. Soap
Chassis	1/2 lb. Soap	Trunk	1/2 lb. Soap	Stairs	1/2 lb. Soap
Oil	1/2 lb. Soap	Tools	1/2 lb. Soap	Tables	1/2 lb. Soap
Grease	1/2 lb. Soap	Parts	1/2 lb. Soap	Benches	1/2 lb. Soap
Brake	1/2 lb. Soap	Assembly	1/2 lb. Soap	Lockers	1/2 lb. Soap
Wheel	1/2 lb. Soap	Finishing	1/2 lb. Soap	Shower	1/2 lb. Soap
Hub	1/2 lb. Soap	Polishing	1/2 lb. Soap	Refr.	1/2 lb. Soap
Valve	1/2 lb. Soap	Painting	1/2 lb. Soap	Freezer	1/2 lb. Soap
Spark	1/2 lb. Soap	Coating	1/2 lb. Soap	Icebox	1/2 lb. Soap
Plug	1/2 lb. Soap	Sealing	1/2 lb. Soap	Stove	1/2 lb. Soap
Cap	1/2 lb. Soap	Waxing	1/2 lb. Soap	Washing	1/2 lb. Soap
Pin	1/2 lb. Soap	Shining	1/2 lb. Soap	Polishing	1/2 lb. Soap
Nut	1/2 lb. Soap	Buffing	1/2 lb. Soap	Waxing	1/2 lb. Soap
Washer	1/2 lb. Soap	Grinding	1/2 lb. Soap	Shining	1/2 lb. Soap
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Bracket	1/2 lb. Soap	Sharpening	1/2 lb. Soap	Waxing	1/2 lb. Soap
Bracket	1/2 lb. Soap	Grinding			


FOR YEARS I'D BEEN
WASTING MONEY ON SOAP
—GROPING IN THE DARK
FOR CORRECT CLEANING
METHODS UNTIL...

THE C. P. P. MAN PRESENTED ME WITH HIS COMPANY'S SOAP CHART. HE TOLD ME IT WOULD QUICKLY SOLVE MY CLEANING PROBLEMS... MAKE IT EASY TO PICK THE RIGHT SOAP FOR EVERY JOB, SO ...

A cartoon illustration of a man in a suit and tie, smiling and pointing his right index finger towards a large chart. The chart is titled "LEGEND" and is divided into several columns and rows, listing various types of equipment and their specifications. The man has a speech bubble above him that says: "I PUT THE CHART ON TRIAL IN MY SUPPLY ROOM".

The chart is titled "LEGEND" and is divided into several columns and rows, listing various types of equipment and their specifications. The columns are labeled: "EQUIPMENT", "SPECIFICATIONS", "EQUIPMENT", "SPECIFICATIONS", "EQUIPMENT", "SPECIFICATIONS", "EQUIPMENT", "SPECIFICATIONS". The rows are labeled: "EQUIPMENT", "SPECIFICATIONS", "EQUIPMENT", "SPECIFICATIONS", "EQUIPMENT", "SPECIFICATIONS", "EQUIPMENT", "SPECIFICATIONS".

NOW I'VE CUT MY
INVENTORY TO SIX
CLASSES OF SOAP AND
REALIZED SUBSTANTIAL
SAVINGS ON MONEY,
LABOR AND
MATERIALS!



**CHOOSE THE RIGHT SOAPS
FOR LAUNDRY USE, TOO!**

COLGATE-PALMOLIVE-PEET has soaps for every need . . . soaps that assure finer work . . . longer lasting linens . . . at less cost. You'll find, too, that pound for pound, C.P.P. Special Laundry Soaps wash

more clothes better than so-called "bargain" soaps.

When you ask for the Hospital Chart from your C.P.P. representative, also ask for full information about Colgate-Palmolive-Peet Laundry Soaps.

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Tri-State Conference of Tidewater States Will Convene April 14-16

For three days, April 14 to 16, the Tri-State Conference of Virginia, North Carolina and South Carolina, will gather in Columbia, S. C., for a study of regional hospital problems.

"Happy Jim" (James A.) Hamilton, first vice president of the A. C. H. A., will lead the opening session at 11:30 a.m. on April 14, with a round table conference. At 1 p.m. the South Carolina Hospital Association will be host to the conference at luncheon.

H. H. McGill, president of the South Carolina Hospital Association, will preside at the afternoon session. John R. Mannix, chairman of the A. H. A. council on association development, will discuss "Cooperative Action Among Hospitals."

Subsequent speakers on the afternoon program will be Lenna F. Cooper, president of the American Dietetic Association, "Administrative Problems of the Dietitian"; Hattie E. Pugh, R.N., assistant director of nursing service, Medical College of Virginia, Richmond, "Educational Opportunities for Nurses in Out-Patient Departments," and Dr. B. C. Willis, Park View Hospital, Rocky Mount, N. C., "Danger and Virtues of General Hospital Care Associations."

The president of the A. H. A., Robert E. Neff, will give the address at the evening's banquet on "Hospital Growth and Community Responsibility."

Friday, April 15, will be North Carolina Day, and that state association's officers, M. E. Winston, president, and James R. McLeod, secretary-treasurer, will have the honor of presiding at sessions.

At the morning session E. B. Crawford, superintendent of the Wesley Long Hospital, Greensboro, N. C., will speak on "Hospitals and Their Relations to the Industrial Commission"; Jennie C. Jones, R.R.L., president of the A. R. L. N. A., will speak on "The Future of the Hospital Record Department," and William A. Dawson, consulting accountant, United Hospital Fund of New York, on "Cost Accounting in the Small Hospital."

In the afternoon Mr. Hamilton will point out the advantages of the A. C. H. A.; Robena C. Anderson, R.N., assistant director of nursing service, hospital division of the Medical College of Virginia, will discuss "Commercial Diseases in a General Hospital"; Evelyn M. Heath, R.N., superintendent of the Northampton

Acconomac Memorial Hospital, Nassawadox, N. C., "How the Rural Hospital Can Best Serve Its Community"; Dr. T. R. Huffines, Asheville Mission Hospital, Asheville, N. C., "Cancer Clinic of Mission Hospital," and Dr. E. W. Williamson, assistant director, American College of Surgeons, "Important Aspects of Medical Staff Organization Applicable to Every Hospital."

At an open meeting that evening Mr. Neff will address the public on the subject of "Hospitals and the Changing Social Order." Dr. Lewis E. Jarrett, president of the Virginia Hospital Association, will preside.

The Saturday morning session, April 16, at which M. Haskins Coleman Jr., secretary-treasurer of the Virginia Hospital Association will preside, will be devoted to a round table discussion lead by Mr. Mannix and Mr. Hamilton.

Inaugurate Group Plan

Twenty-seven leading southern California hospitals inaugurated group hospitalization on March 15 as a result of the granting by the state insurance commission of the first permit to be issued under provisions of the new assembly bill. The permit was presented at the Western Hospital Association meeting.

Nursery Mixup Counteracted by Action of State Association

To counteract adverse publicity arising from a reported "mixup" of babies at an eastern Pennsylvania hospital, the public relations and publicity committee of the Hospital Association of Pennsylvania set to work to publicize the value of footprinting identification for infants.

When the whole value of footprinting babies was questioned by William P. Hoffman, director of the Bureau of Criminal Investigation at Harrisburg, Pa., the Magee Hospital arranged to have its system of footprinting babies tested by a Bertillon expert from the Pittsburgh police department. The expert, who himself had doubted the value of such footprints and had expressed the opinion that they probably would be good only for ten days or two weeks, later asserted that if the footprinting technic is carefully done, with the proper amount and type of ink, so that the footprints show the regular ridge formation of the foot, they will provide identification regardless of how much time has elapsed.

Publicity releases to hospitals in Pennsylvania urged that they take steps to give their local press stories of the test.

Western Institute Program Announced for Meeting at Stanford University

The program for the Western Institute for Hospital Administrators, to be held at Stanford University, August 8 to 19, was announced last month.

The institute is sponsored by the American College of Hospital Administrators, the Association of Western Hospitals and the Association of California Hospitals, jointly with the university.

Mornings will be devoted to lectures, afternoons to field trips in outstanding hospitals and evenings to panel discussions.

The lecture program is as follows: "Hospitals' Contribution to Medical Education," Dr. Ray Lyman Wilbur, president, Stanford University; "Relation of Hospitals to Public Health," Dr. Jacob C. Geiger, San Francisco commissioner of health; "Fundamentals of Hospital Organization," James A. Hamilton, first vice president, A. C. H. A.; "Medical Staff Organization and Relationships," Dr. B. W. Black, second vice president, A. C. H. A.; "Financial Support and Control of Hospitals," Dr. C. Rufus Rorem, American Hospital Association; "Nursing Education and

Nursing Service," Sister John Gabriel, educational director, Sisters of Charity of Providence, Seattle; "Structural Rehabilitation, Maintenance and Operation," Dr. A. K. Haywood, Vancouver General Hospital.

"Medical Social Service," Margaret Spiers, Alameda County Hospital, Oakland, Calif.; "Food Service," Mrs. Lucille Waite, Fairmont Hospital, San Leandro, Calif.; "Administrative Aspects of Roentgenology, Pathology and Special Therapy Departments," Dr. Robin C. Buerki, president-elect, A.C.H.A.; "Medic-Legal Problems," Howard Burrell, Los Angeles, Calif., and "Medical Records," Dr. Malcolm T. MacEachern, American College of Surgeons.

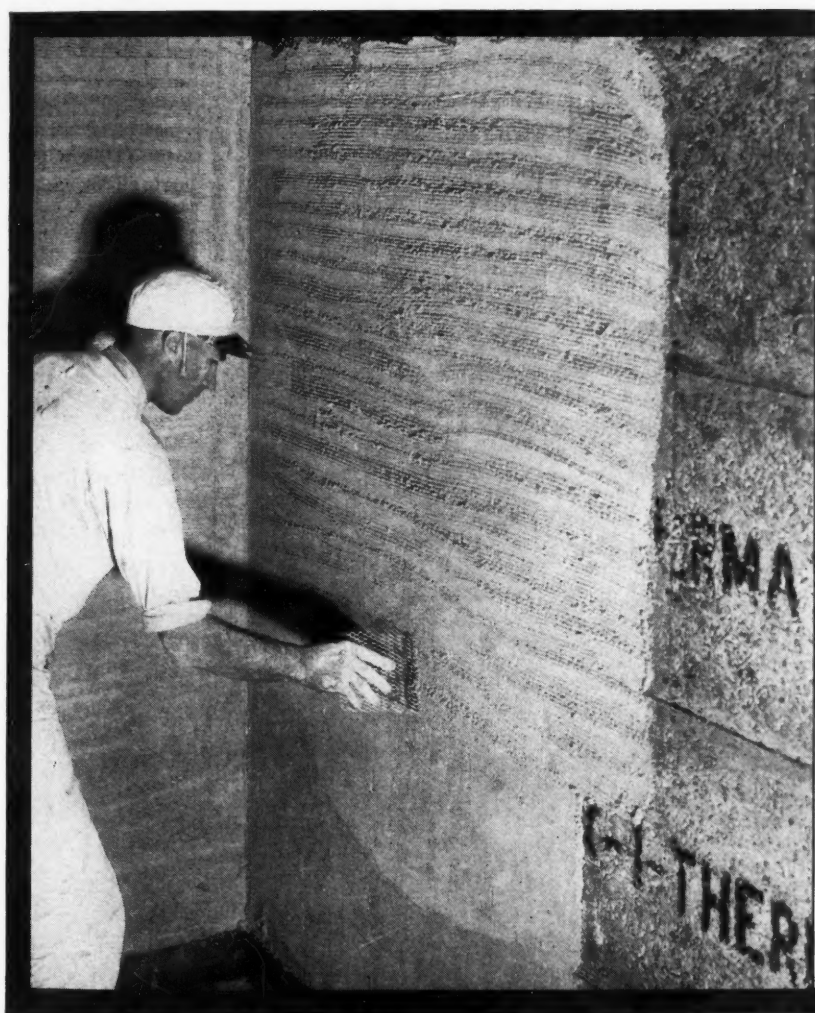
The institute will be directed by Doctor Black, chairman of the advisory and administrative committees.

The institute will be open to hospital administrators, administrative assistants and executive department heads who are actively engaged in administrative work. Full information may be obtained from the Association of Western Hospitals, 1182 Market Street, San Francisco.

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**THERMAX—THE FIRE-RESISTANT
INSULATING SLAB—DOES THE JOB OF 3
ORDINARY BUILDING MATERIALS:**

1 *It is highly efficient insulation. Thermax in roofs, ceilings, and side walls saves fuel and guards comfort permanently.*

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If you're planning an addition or modernizing job in your hospital, suggest Thermax to your architect—for roof decks, partitions, furring and plaster base, thermal and sound insulation. Because it combines all these functions, usually at a saving, leading architects are specifying more Thermax every day for use in hospitals, schools, and public buildings. It is approved by building departments of leading cities in the United States and Europe, and classified by the Underwriters' Laboratories, Inc. Send the coupon today.

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Southeastern Conference Will Direct Program Toward Sectional Problems

The second annual conference of the Southeastern Hospital Conference in Birmingham, Ala., April 7 to 9, will draw speakers from all sections of this country and Canada, as well as the South, for an unusually "meaty" program has been arranged for that meeting.

Clyde L. Sibley, superintendent of the Birmingham Baptist Hospital and president of the conference, will call the convention to order on Thursday morning, April 7. Dr. A. C. Jackson will extend greetings as president of the Alabama Hospital Association.

A varied program has been arranged for the opening session. Harry Smith, superintendent of the City Hospital at Columbus, Ga., will discuss cultivation of community pride in the municipal hospital; Nell Stockton, technician, South Highland Infirmary, Birmingham, the live laboratory; Sister Lydia, R.N., superintendent of St. Vincent's Hospital, Birmingham, management of supplies, and O. K. Fike, managing director, Grace Hospital, Richmond, Va., "The Dietitian, a Master Salesman."

T. F. Alexander, superintendent of the Tampa Municipal Hospital and president of the Florida Hospital Association, will preside at the afternoon session at which Dr. A. J. Hockett, superintendent of the Touro Infirmary, New Orleans, and president of the Louisiana Hospital Association, will discuss the Social Security Act.

Other speakers will be Dr. T. Dwight Sloan, superintendent of the Flagler Hospital, St. Augustine, Fla., who will discuss the business office; O. G. Pratt, superintendent of the Salem Hospital, Salem, Mass., and chairman of the A. H. A. section on small hospitals, who will speak on "Promotion of Popular Interest in a Community Hospital," and Dr. A. Street, president of the Mississippi Hospital Association, the practical standards of medical service in small hospitals. Dr. Russell H. Oppenheimer, medical director, Emory University Hospital, Atlanta, will lead the round table discussion following the afternoon program.

Alden B. Mills, managing editor, *The MODERN HOSPITAL*, Chicago, will be the opening speaker on the Friday morning program. His subject will be "Public Relations in Small Hospitals." John R. Mannix, assistant director of the University Hospitals, Cleveland, will speak on cooperative action among hospitals, and William A. Dawson,

consulting accountant, United Hospital Fund of New York, will discuss cost accounting in the small hospital.

Fred Walker, superintendent of the Duval County Hospital, Jacksonville, Fla., will preside at the Friday luncheon at which four prominent hospital leaders will discuss "Training in Hospital Administration" in brief five-minute talks; they are: James A. Hamilton, superintendent of the Cleveland City Hospital; Dr. Lewis Jarrett, administrator of the Medical College of Virginia Hospitals, Richmond; Dr. G. Harvey Agnew, president elect of the A. H. A., and Mr. Mannix.

Dr. A. Street, president of the Mississippi Hospital Association, will preside at the afternoon session. Appearing on this program will be Annice Jackson, R.N., operating room supervisor, Hillman Hospital, Birmingham, who will discuss arrangement and equipment of the operating room theater; Alma Clyde Foust, R.N., superintendent, Colbert County Hospital, Sheffield, Ala., management of the anesthesia department of a small hospital; Doctor Jarrett, the values and technics of obtaining necropsies.

The chief address at the convention banquet on Friday evening will be given by Doctor Agnew. Dr. James R. Garber, Birmingham, will be toastmaster and Dr. James S. McLester, past president of the A. M. A., will extend greetings from the medical profession.

At the final session on Saturday morning, Edward Groner, manager, Hospital Service Association of New Orleans, will discuss latest trends in plans for hospital care, and Harris Burns, secretary, board of trustees, Birmingham Baptist Hospital, the duty of the governing board. Graham Davis of the Duke Endowment will open the discussion at the round table on group hospitalization.

University to Operate Hospital

The University of Chicago will merge its medical clinic with the Chicago Lying-In Hospital within the next month, according to a recent announcement released by the university. The university will take over the hospital's assets of \$2,800,000 and, in return, will strengthen the hospital financially. The hospital will be renamed after Dr. Joseph B. De Lee, who founded it nearly a half century ago in a Maxwell Street tenement.

President Robert E. Neff Will Address the Opening of Ohio Meeting April 5

"Hospitals and the Changing Social Order" will be the title of the opening address by President Robert E. Neff of the A. H. A. before the Ohio Hospital Association meeting April 5 to 7 at Columbus.

Meeting concurrently will be the Ohio Dietetic Association, the Ohio record librarians, nurse anesthetists, physiotherapy association, the Hospital Obstetric Society of Ohio and the Ohio Society of Medical Technologists. These allied associations each will hold a joint session with the hospital association.

At a session on personal management in hospitals planned for the opening day, April 5, James A. Hamilton, chairman, A. H. A. committee on personnel relations; Bertha E. Beecher, personnel director, Christ Hospital, Cincinnati, and Winifred McL. Shepler, personnel director, Cleveland City Hospital, will speak. Another address arranged for that day will be "Community Help on Hospital Improvements" by Ada I. Leonard, superintendent of the Middletown Hospital, Middletown.

The following day the convention will hear Gerhard Hartman, executive secretary of the A. C. H. A., discuss an educational program for hospital administrators. Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, will lead a round table discussion at a joint meeting with medical record librarians. The same day Doctor MacEachern also will speak on "The Need of Licensing Hospitals."

At the convention banquet the welcoming address will be given by Gov. Martin L. Davey of Ohio and the guest speaker will be Count Sederholm of Denmark.

Hospital service plans will be discussed by John R. Mannix of the University Hospitals, Cleveland, at a panel round table on April 7.

At a session on plant and maintenance the speakers will be Francis R. Van Buren, superintendent, Children's Hospital, Cincinnati, and G. F. Stephens and R. Starr Parker, both of Christ Hospital, Cincinnati.

Convention Dates Announced

Officials of the Catholic Hospital Association have announced that the twenty-third annual convention of the association will be held at the 174th Regiment Armory, Buffalo, N. Y., June 13 to 17.

TWO STAMPS WITH THE SAME MEANING

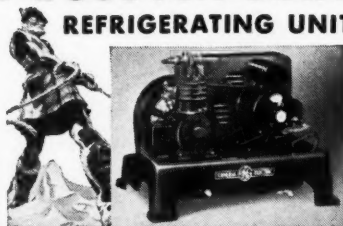


ELECTRIC REFRIGERATION EQUIPMENT

♦ Ask any user of General Electric refrigeration equipment about its value... its dependability... its economy... how much more thrifty it is than old-fashioned methods of refrigeration. Get ALL the facts before you decide!
♦ It doesn't pay to gamble when

selecting refrigerating apparatus. For you are making a long-time investment that will either save you money or cost you money.
♦ Before you invest a penny for any type of refrigeration equipment, see the General Electric dealer or write direct to General Electric Co., Commercial Refrigeration Section CX4, Nela Park, Cleveland, Ohio.

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General Electric offers a complete line of refrigeration equipment for *your* hospital. Anything you need. From portable fixtures with matched refrigeration units built-in, to elaborate installations for which G-E factory-trained experts are available in planning and engineering.



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GENERAL  ELECTRIC
COMMERCIAL REFRIGERATION

N. C. Industrial Employees Benefit Under New Rate for Hospital Insurance

A new and important development in hospital care insurance in North Carolina is being watched with interest by students of the movement elsewhere. Felix A. Grisette, executive director of the North Carolina Hospital Savings Association, has arranged with the manager of three knitting mills in Morganton, N. C., to accept the 1400 employees of these mills at a rate of \$1 per month for the employees and their families for ward care up to 30 days in any one year. One-half of the premium is being paid by the mill management and the other half by the employees.

The plan originally was worked out by S. K. Hunt, business manager of the Grace Hospital, Morganton. It was originally proposed that it be merely a one-hospital plan but, through agreement between Mr. Hunt and Mr. Grisette, it came into the Hospital Savings Association.

A special feature of the plan is that Grace Hospital agrees to accept these patients at a flat all-inclusive rate of \$3 per day, which is somewhat lower than the association now pays to hospitals. This explains in part why the association is able to accept them for only \$1 per month per family when its usual fee is \$1.60 per month per family. The hospital is willing to accept this rate because its costs are low and at present approximately one-half of its patients are unable to pay hospital bills.

The Hospital Savings Association has been growing at a cumulatively faster rate. Its report as of March 1 shows a total membership of more than 60,000.

Chicago Hospital Association Affiliates With Local Council

By a vote of 24 to 2 the Chicago Hospital Association, at a meeting late in February, agreed to become the administrators' section of the Chicago Hospital Council. The association will retain its present constitution and by-laws until further action of the council, but will discontinue the collection of dues. Administrators who have been members of the association will continue to be council members.

By this action the confusion in Chicago as to what organization officially speaks for the hospitals is largely eliminated. The only other hospital organization now is the hospital section of the health division of the Council of Social Agencies.

Coming Meetings

- Ohio Hospital Association.**
Next meeting, Columbus, April 5-7.
- Southeastern Hospital Conference.**
Next meeting, Birmingham, Ala., April 7-9.
- Alabama Hospital Association.**
Next meeting, Birmingham, April 8.
- Texas State Hospital Association.**
Next meeting, Houston, April 8-9.
- Tri-State Hospital Conference (Virginia, North Carolina, South Carolina).**
Next meeting, Columbia, S. C., April 14-16.
- South Carolina Hospital Association.**
Next meeting, Columbia, April 14-16.
- Mississippi Hospital Association.**
Next meeting, Jackson, April 18.
- Mid-West Hospital Association.**
Next meeting, Kansas City, Mo., April 21-22.
- American Nurses' Association, National Organization for Public Health Nursing and National League of Nursing Education.**
Biennial convention, Kansas City, Mo., April 24-29.
- Pennsylvania Hospital Association.**
Next meeting, Pittsburgh, April 27-29.
- Louisiana Hospital Association.**
Next meeting, New Orleans, May 2.
- Tri-State Hospital Association (Indiana, Illinois, Wisconsin).**
Next meeting, Chicago, May 4-6.
- New York State Dietetic Association.**
Next meeting, Syracuse, May 5-6.
- Kansas State Hospital Association.**
Next meeting, Wichita, May 10-11.
- Hospital Association of New York State.**
Next meeting, Buffalo, May 18-20.
- Minnesota Hospital Association.**
Next meeting, Minneapolis, May 19-21.
- New Jersey Hospital Association.**
Next meeting, Jersey City, June 2-4.
- National Executive Housekeepers Assn.**
Annual Congress, Washington, D. C., June 2-5.
- Catholic Hospital Association.**
Next meeting, Buffalo, N. Y., June 13-17.
- Manitoba Hospital Association.**
Next meeting, Selkirk, June 23-24.
- Michigan Hospital Association.**
Next meeting, Marquette, June 23-24.
- Canadian Nurses Association.**
Next meeting, Halifax, N. S., July 4-9.
- National Hospital Association.**
Next meeting, Hampton, Va., Aug. 14-16.
- American Hospital Association.**
Annual convention, Dallas, Tex., Sept. 26-30.
- American Protestant Hospital Association.**
Next meeting, Dallas, Tex., Sept. 30-Oct. 2.
- American Dietetic Association.**
Next meeting, Milwaukee, Oct. 9-14.
- Missouri State Nurses' Association.**
Next meeting, Kirksville, Oct. 17-19.
- Association of Record Librarians of North America.**
Tenth Annual Conference, New York, Oct. 17-21.
- American College of Surgeons.**
Next meeting, New York, Oct. 17-21.
- Ontario Hospital Association.**
Next meeting, Toronto, Oct. 19-21.
- American Public Health Association.**
67th Annual Meeting, Kansas City, Mo., Oct. 25-28.
- Kansas Hospital Association.**
Next meeting, Pratt, Oct. 29.

Contribution for Indigent Care

Four hospitals in Luzerne County, Pennsylvania, will be aided during 1938 by a contribution of \$100,000 from the Luzerne County Institutional Board. These hospitals have been carrying a steadily increasing charity patient load since 1929 as contributions did not even partially take care of the indigent cases treated. The hospitals to be benefited are the Wilkes-Barre General Hospital, Mercy Hospital and Wyoming Valley Homeopathic Hospital, of Wilkes-Barre and the Pittston City Hospital.

Texas Association Will Meet With Allied Groups in Houston

The Texas State Hospital Association and three allied associations, the record librarians, nurse anesthetists and occupational therapists, will convene at Houston April 8 and 9.

The convention will open with an address by C. E. Hunt, president of the Texas State Hospital Association and superintendent, Lubbock Sanitarium, Lubbock. Robert Jolly, administrator of the Memorial Hospital, Houston, then will give a clinical demonstration of the "Superintendent's Staff Conference." This will be followed by a round table lead by Mrs. Martha Robertson, R.N., of the Medical and Surgical Hospital, San Antonio.

Dr. Bert Caldwell, executive secretary of the A. H. A., will be the luncheon speaker. Following the luncheon, Mrs. Inet Gilbert of the Methodist Hospital, Houston, will give a clinical demonstration of hospital records. "Old Age Pensions and Unemployment Insurance for Hospital Personnel" will be discussed by a representative of an insurance company.

Dr. R. C. Buerki, president elect of the A. C. H. A., will be the guest speaker at the dinner on Friday.

The convention will close Saturday morning with speeches by Mrs. Elsie Maurer Kibbe, R.N., instructor of nursing education, University of Texas, and Gerhard Hartman, executive secretary, A. C. H. A., and a tour of Jefferson Davis Hospital.

Illinois Association Divides Into Ten Regional Districts

Division of the state into ten districts, each with its own chairman and with local meetings periodically, was decided upon at the Illinois Hospital Association meeting in Springfield on March 11 and 12. The meeting was well attended by administrators of hospitals throughout the state, particularly from outside of Chicago.

One of the principal purposes of the ten-way division is to get hospitals to cooperate with one another more effectively locally and to give more support to the legislative program. Albert Hahn, executive secretary of the Indiana Hospital Association, described Indiana's experience with its district meetings. Arden Hardgrove, representing the A. H. A., and E. C. Pohlman, chairman of the state legislative committee, discussed the legislative program. An outstanding roundtable conference was led by Dr. M. T. MacEachern.



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Names in the News

Administrators

JAMES A. HAMILTON, whose political cleanup of Cleveland's City Hospital has attracted national attention since he became superintendent there during the summer of 1936, has resigned to accept the superintendency of the New Haven Hospital, New Haven, Conn. The new position "fits into my lifetime aspirations within the field of hospital administration," Mr. Hamilton wrote to FRED W. RAMSEY, Cleveland welfare director. The New Haven Hospital is a part of the Yale University School of Medicine. Mr. Hamilton said he would remain at Cleveland City Hospital until Mr. Ramsey can choose his successor, but in no event later than July 1.

ARDEN E. HARDGROVE, for two and one-half years assistant executive secretary of the American Hospital Association, devoting special attention to its legislative program and to the development of state and regional hospital associations, in March became administrator of the John N. Norton Memorial Infirmary, Louisville, Ky. From 1922 to 1935 Mr. Hardgrove was superintendent of the City Hospital, Akron, Ohio, and from 1933 to 1935 also served as executive secretary of the Ohio Hospital Association.

DR. NESSIB S. KUPELIAN is the acting superintendent of Pownal State School, Pownal, Me.

DR. WINFRED OVERHOLSER, superintendent of St. Elizabeth's Hospital, Washington, D. C., has been appointed professor of psychiatry and executive officer of the department of psychiatry at George Washington University School of Medicine.

DR. WALTER P. GARDNER, 33, is the new superintendent of the Anoka State Hospital, Anoka, Minn., succeeding Dr. M. W. KEMP. Doctor Gardner was in private practice of neurology and psychiatry in St. Paul until he entered institutional practice of psychiatry as an employee of the state of Minnesota in 1933, where he was resident physician for the Hastings State Hospital. He resigned from that post in 1935 to become assistant superintendent of the Fergus Falls State Hospital.

DR. ISADORE BRICKMAN has been appointed superintendent of the State Colony Training School at Alexandria, La.

DR. FREDERICK CHARLES LORENZEN, Elgin, N. D., has been named superintendent of the North Dakota State Hospital for Insane, Jamestown, N. D.

Appointed to New Posts



James A. Hamilton (left), administrator of the Cleveland City Hospital, who has been appointed superintendent of the New Haven Hospital, and Arden E. Hardgrove, former A.H.A. assistant executive secretary, who has been named the new administrator of the John N. Norton Memorial Infirmary, Louisville, Ky.

DR. FRANK W. DEASON, Grafton, N. D., recently succeeded Dr. JAMES P. AYLEN as superintendent of the North Dakota State School (for the feeble-minded) at Grafton.

FRANCIS C. LEUPOLD of Philadelphia has been appointed superintendent of Jamaica Hospital, Jamaica, N. Y., to fill the vacancy caused by the death last December of Dr. EDWARD DAUGHERTY. Mr. Leupold served in a like capacity in hospitals in Philadelphia and Norristown, Pa.; Camden, N. J., and San Diego, Calif.

CONSTANCE MCINTOSH, Hapville, Ga., has assumed charge as superintendent of the Newberry County Hospital, Newberry, S. C.

DR. GUY WILLIAMS, former director of the Cleveland State Hospital, Cleveland, and Dr. R. E. BUSHONG, former director of the Lima State Hospital, Lima, Ohio, exchanged posts on March 10. The transfer was made by Mrs. MARGARET ALLMAN, state welfare director.

DR. C. S. WOODALL, assistant superintendent of the Walter E. Fernald State School, Waverley, Mass., has been appointed superintendent of the Brandon State School (for the feeble-minded) at Brandon, Vt.

BERNICE DALEN, formerly of Jackson, Miss., is the new superintendent of the Lutheran Hospital, Norfolk, Neb.

LOUISE M. COLEMAN recently was re-elected superintendent of the House of the Good Samaritan, Boston, for the thirty-fourth consecutive year.

DR. MAX A. BAHR on March 1 completed forty years of service as superintendent of the Central State Hospital, Indianapolis. The day was a special occasion for Doctor Bahr, with gifts, motion pictures and talks.

DR. BENJAMIN F. COLEGROVE, new superintendent of the Onondaga General Hospital, Onondaga, N. Y., is planning major improvements at that institution, it has been announced.

Department Heads

MRS. JE HARNED resigned March 15 as director of the school for record librarians at Rochester General Hospital, Rochester, N. Y., and after a vacation will take up her new duties at Duke University Hospital, Durham, N. C.

DR. EDWIN HOWE FISKE has confirmed a report that he has resigned as director of surgery at Kings County Hospital, Brooklyn, N. Y. Doctor Fiske will continue in the position for another year until he can retire on a pension.

HARRIETT L. BEEK, R.N., is the new head of the school of nursing at Mount Sinai Hospital, Philadelphia, instead of Mount Sinai Hospital, New York, as previously reported. GRACE A. WARMAN, R.N., is principal of the nursing school at Mount Sinai, New York.

Deaths

AXEL M. GREEN, D.D., superintendent of Emanuel Hospital, Portland, Ore., for the last twenty-one years, died March 5 in the hospital whose growth he had nurtured to one of the leading institutions of its kind on the Pacific Coast.

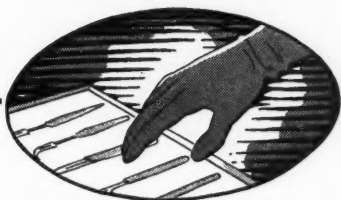
AARON WALDHEIM, philanthropist and prominent St. Louis business man, died recently at the age of seventy-four. For many years he was president of the board of trustees of the Jewish Hospital of that city.

LORETTA M. SHERIDAN, for twelve years superintendent of the Charleroi Monessen Hospital, Charleroi, Pa., died March 3 following two weeks of serious illness.

DR. SANFORD M. WITHERS, director and radiation therapist of the Denver Cancer Clinic and the owner of patents on appliances widely used in radium and x-ray therapy, died of aplastic anemia and bronchial pneumonia recently in the hospital of the Rockefeller Institute for Medical Research. He was 47 years of age.

Miscellaneous

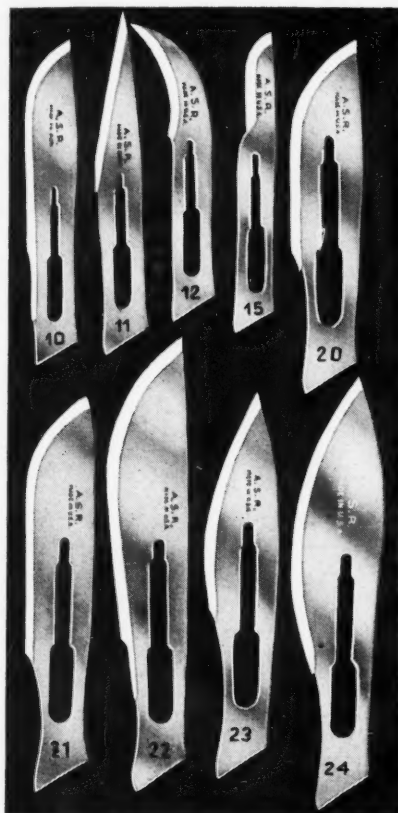
DR. A. C. JACKSON, Jasper, Ala., has been named president of the Hospital



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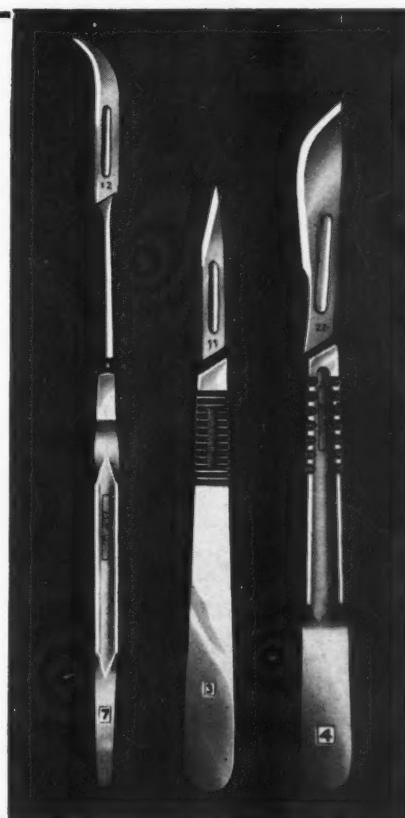
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Service Corporation of Alabama succeeding Ed S. Moore, who became general business manager of the organization. Other officers named were: Sister Lydia, St. Vincent's Hospital, Birmingham, vice president; Dr. C. N. Caraway, treasurer, and Dr. D. S. Moore, secretary.

DR. W. W. LONG has announced that DR. BYRD LONGINO has purchased an interest in the Long Hospital, Sulphur Springs, Tex., and that he will continue his association with the institution.

DR. CARL M. PETERSON is the executive secretary of the American Medical Association's new council on industrial health. Doctor Peterson for eight years was in charge of internships and residencies of the council on medical education and hospitals. DR. FRITJOF H. ARESTAD, who has been with the council on medical education and hospitals for the last ten years, has succeeded Doctor Peterson.

DR. RAY PALMER BAKER, assistant director of Rensselaer Polytechnic Institute, has been renamed president of the board of directors of Samaritan Hospital, Troy, N. Y., for his third successive term.

IRA V. HISCOCK, professor of public health in the Yale University school of medicine, has been elected president of the National Health Council for 1938.

New England Administrators

(Continued from page 104.)

ward helper increasing in numbers and believes that they will prove a great asset if correctly taught and supervised. "But plans must be made for their teaching," she emphasized.

In a discussion of the annual report by Dr. William O. Rice, superintendent, Rhode Island Hospital, Providence, R. I., he emphasized the importance of giving the report wide distribution, recommending that it be sent to libraries, schools and local papers in addition to the usual list of friends, benefactors and members of the staff. He showed the advantages of eliminating long medical statements. The introduction of effective illustrations are worth the cost, he has found.

Coincident with these meetings attended by the administrators, some 200 trustees of New England hospitals, men and women, assembled behind closed doors to consider hospital affairs. This gathering was more significant from the standpoint of the interest shown and the desire to affiliate with hospital activities than for any outstanding discussion of fundamental problems. From a list of 18 questions the participants selected those they wanted to hear discussed.

The ensuing round table produced an interchange of ideas on such matters as hospital auxiliaries, the growing tendency to abolish training schools in small hospitals, smoking in the hospital and the disadvantages that may result from belonging to a community fund or chest. Frank O. Robson, chairman of the board of trustees, Harrington Memorial Hospital, Southbridge, Mass., presided.

Exhibits ran fully 30 per cent higher than last year and there was sufficient variety in the line-up to appeal to every hospital worker. If the showing of a portable sanitary mop shaker lacked appeal there was an air conditioned ambulance equipped with hot and cold running water to tempt the curiosity.

Officers of the New England Hospital Association for the coming year are: Doctor Rice, president; Warren F. Cook, New England Deaconess Hospital, Boston, vice president; Oliver Pratt, Salem Hospital, Salem, Mass., treasurer; Dr. A. E. Engelbach, Cambridge Hospital, Cambridge, Mass., secretary, and Dr. W. Franklin Wood, McLean Hospital, Waverly, Mass., and Dr. Wilmar M. Allen, Hartford Hospital, Hartford, Conn., trustees.

Lowest Hospital Service Rate

The Flint-Goodridge Hospital of Dillard University, New Orleans, is said to have the lowest group hospital service rate now in existence. It is called "A Penny a Day" plan because the fee for each subscriber is \$3.65 per year; a subscriber and his wife pay \$6 per year, and the subscriber and family including all children under eighteen years of age pay \$8.50. These rates entitle subscribers to full service and 50 per cent discount on the same services to the family. The benefits include twenty-one days in a ward, with board and room, operating room, x-ray, routine medicines and laboratory examinations. At the end of its first year the plan had 2,492 enrollees.

Arrest Lottery Promoters

During February the charter of the Will Rogers Memorial Hospital, Chicago, was revoked, the corporation dissolved and its officers, directors and trustees removed as the result of a complaint that the hospital was operating a lottery plan in violation of its charter. Late in March two men were arrested by a U. S. postal inspector as agents of the lottery promoters. One agent said that 60 per cent of the collections from this and other lotteries was retained as promoters' profits and 40 per cent was distributed as prizes.

Fifteen Hospitals Represented

Fifteen hospitals were represented at the annual meeting of the Maine Hospital Association held at the Central Maine General Hospital in Lewiston. Dr. Joelle Hiebert presided. The following officers were elected for the ensuing year: president, Dr. Joelle C. Hiebert of the Central Maine General Hospital, Lewiston; vice president, Dr. Stephen Brown of the Maine General Hospital, Portland, and secretary-treasurer, Margaret A. Hebert, R.N., of the Gardiner General Hospital, Gardiner.

Twin City Plan Serves 10,000

The Minnesota Hospital Service Association paid out \$286,933 in hospital bills for 10,114 individuals during 1937, according to E. A. van Steenwyk, executive secretary. Altogether the association furnished 73,327 hospital days, of which 42,521 were used by members and the rest by dependents.

READER OPINION

Out of the Breezes

March 8th, 1938

Sirs:

I don't mind you using my name and the pictures of the warehouse in your publication [March issue, p. 83—Ed] provided you are accurate with your statements. I have perused the document which was forwarded to you under date of November 26th regarding the warehouse and nowhere can I find the statement that the Eloise Hospital and Infirmary at Eloise, Michigan, is an institution of nearly 3,000 beds. As a matter of fact, we have 9253 persons in the institution right today and we have not been below 7,000 for several years, so apparently this 3,000 idea that you got you picked out of the breezes somewhere.

I have always had difficulty in persuading the A.M.A. in their annual directory to state the number of patients we have in the institution. They insist on dividing it into two separate institutions. I send them the information and they make it up to suit themselves regardless of how I try to persuade them that we have an institution as large as we have. I realize that it is hard for anyone to understand how it is possible to have an institution of this size, but I can assure you if you will come here and get some counters to take a census, you will discover that we are correct in our statement. This is just a tremendous institution and I say, without fear of contradiction, this is the largest institution of any kind in the world. It is all on one piece of ground, under one management and there is no hocus-pocus about it.

I am wondering if somehow or other you could correct the information given in the first paragraph, which was apparently written by someone else than ourselves, because a \$313,000 warehouse and one as large as this picture shows would be out of place in an institution of less than 3,000 and I would not want people to think that I was in the business of squandering money at that rate.

T. K. GRUBER, M.D.
Superintendent.

Eloise Hospital and Infirmary
Eloise, Mich.

From Fountains To Bottled Blood

Hospitals Have Used Webb's Alcohol



A BLOOD TRANSFUSION IN 1874

T. F. Healy Collection

Today, blood for transfusion costs at least \$25 a pint. Before Landsteiner's discovery in 1901 that all human blood is not alike, but is divided into four groups, transfusions could and did cost many lives due to clots induced by mixing incompatible blood groups. How many deaths arose from other hazards when blood was allowed to jet from the donor's arm into a "fountain" from which it flowed by gravity into the patient's arm, is not known.

DOCTORS making blood transfusions in 1874 knew little about blood groups. The success of their operation—usually performed with a crude "fountain"—was won or lost on the throw of a dice, and "blood banks" with their deposits of bottled blood, which were to save thousands of lives, existed only in their wildest dreams.

Yet selecting alcohol for hospitals in 1874 was not a matter of guesswork. Doctors had only to specify Webb's—the standard for American hospitals since 1835—to be sure they were getting the best.

And in 1938, this is even more true. For, with the fusion of the time-honored House of Webb in 1915

with the U. S. Industrial Alcohol Co., alcohol manufacture passed from a craft into a science.

Today, hospitals are getting better alcohol than ever before and, incidentally, using more Webb's and U.S.I.-U.S.P. alcohols than any other single brand. You, too, can be sure—by specifying Webb's or U.S.I.-U.S.P.



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LITERATURE *in* ABSTRACT

Conducted by E. M. Bluestone, M.D., and Joe R. Clemmons, M.D.

Tuberculosis Clinic Survey

This report deals with an analysis of data obtained by questionnaire in a survey of tuberculosis clinics in the United States. It was possible to obtain satisfactory information from 639 clinics out of approximately 1000 permanent clinics.*

Two-thirds of the clinics were established during the fifteen years since 1920, particularly during the five-year period from 1920 through 1924. Seventy per cent of the entire number of clinics were devoted to consultation and/or diagnosis, with only eighteen devoted exclusively to consultation. The remaining 30 per cent of all clinics were engaged in treatment or follow-up in conjunction with consultation or diagnosis or both. Only five clinics were devoted mainly to treatment and four of these five were strictly pneumothorax stations.

Two-thirds of all the clinics reported no charges for their service. But in practically every case in which a charge was made, the amount charged was contingent upon the patient's ability to pay. In more than half of the clinics the admission was not determined by the economic status of the patient; in the others economic considerations did determine the patient's eligibility to admission to clinic facilities. In only 15 per cent of all clinics was it required that the patient be referred by a physician. The clinics were used in many instances as teaching centers for medical and nursing students.

With regard to the availability of x-ray, fluoroscope and laboratory facilities, particularly sputum testing, it seems that the overwhelming majority of tuberculosis clinics have ready access to the foregoing facilities. In approximately one-quarter of these clinics, however, laboratory facilities were available outside of the clinic, mainly in state and local health departments. Use of tuberculin was reported in more than 90 per cent of all clinics and in one-fourth use was also made of lipiodal.

More than two-thirds of all clinics reported a single physician in attendance and one or two nurses. Less than half reported other personnel such as clerks, technicians and the like. Physicians were paid, on an average, \$3 per hour.

The report deals, in addition, with the extent to which pneumothorax treatments and other collapse measures

are used, the use of heliotherapy and the experimental and research work done in the clinics. Clinic practice is in many instances integrated with a system of home supervision and efforts of an educational character. The review draws attention to three types of clinics: (1) the permanent clinic, (2) the itinerant clinic and (3) the occasional clinic. Annual expenditures for carrying on the activities of the clinics are between \$7,000,000 and \$8,000,000, from funds obtained from both public and private sources.

*Nelson, Marion: Practice in Tuberculosis Clinics in the United States, *Am. Rev. Tuber.* 36:619 (Nov.) 1937. Abstracted by Eli H. Rubin, M.D.

Film-Preventing Detergents

This article deals with the relative value of film prevention and auxiliary chemical disinfection of dishes and table ware.*

The authors have made bacteriologic studies of (a) the relative sanitational value of a film-preventing detergent alone, (b) in conjunction with an auxiliary germicide (sodium hypochlorite) and (c) of detergents lacking specific film-preventing properties, alone and in conjunction with sodium hypochlorite. The results indicate that although the use of sodium hypochlorite is definitely beneficial in conjunction with film-forming detergents, the presence of alkaline earth soap film prevents the complete effectiveness of this germicide.

It is pointed out that the character of the water supply in dishwashing is a factor of the utmost importance in determining the efficiency of the cleaning operation.

Insoluble compounds used in dishwashing, especially soaps, are deposited as films on the articles washed and also on equipment. This condition is undesirable both from esthetic and sanitary points of view.

Where an adequate supply of hot water is not available, the use of an auxiliary germicide (compound of chlorine) is recommended in addition to alkaline detergents. Bacterial retention resulting from film-forming properties is relatively high.

Detailed description of the various experiments undertaken is given. The use of hypochlorite either in the washing solution or as a final rinse improved the results obtained with all of the detergents tested. The advisability of

treatment with an auxiliary germicide when dishes have been washed with a film-preventing detergent is left open. Standard dishwashing machines are not equipped for the use of an auxiliary germicide. Under these conditions hand rinsing would be required which could hardly be considered practicable.

*Hall, George O., and Schwartz, Charles: Sanitary Value of Sodium Metaphosphate in Dishwashing, *Industrial and Engineering Chemistry*, January 1938. Abstracted by J. Goodfriend.

Sterilizing With Lamps

The germicidal power of sunlight, even if both ultra-violet and infra-red rays are filtered out, is well known. The shorter wave lengths from the sun have a strong lethal action on bacterial growth, but, readily absorbed in air, remain effective only at short distances from the source.*

Sterilizing lamps of special glass, containing low pressure mercury vapor and a mixture of inert gases, have definite bactericidal action. The lamps are tubular in shape and keep the path of the rays within the tube as short as possible. The temperature of the tube is a few degrees above room temperature. The germicidal action of these lamps is proving an effective substitute for direct sunlight.

*Unsigned: Sterilization by Radiation, Heating, Piping and Air Conditioning, January 1938. Abstracted by Barbara Allen.

Contaminated Food

Although we expect commercially distributed food to be harmless, it is apparent after some research that such is not the case. Too often injurious material gets into our food.

This has been found to occur in the following ways: negligence in the removal of fumigants known to be toxic to man; the practice of using renovated barrels which previously contained arsenic or lead compounds; the use of dyes containing cadmium sulphide, zinc sulphide, barium sulphate and varying amounts of lead; spray residue, the use of containers containing lead for food having an affinity for such metals; the addition of food preservatives, and the direct contact of food with poorly stored insecticides, raticides and other poisons.

In order to prevent this food contamination there must be rigid supervision by those who are responsible for our food supply, both at home and in industry. It is the purpose of this report* to promote educational and legal means to reduce illness from this cause.

*Hunter, Albert C.: Chemical Contamination of Food, Supplement to *Am. J. Pub. Health* 28:2 (Feb.) 1938. Abstracted by Kay Carney.

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The patented curved finger styling eliminates glove tension. These extra advantages, found only in Wiltex White and Wilco Brown Latex gloves, are demonstrated in the long life and unprecedented "finger tip" sense of touch they provide. Only in these gloves can you have all three: sensitivity, flexibility, and toughness. And . . . through your specification of Wiltex White, you have the utmost in service and final economy—in Wilco Brown, a lower first cost.

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Supplementing the Nurse

In recognition of the low ratio of nursing personnel to patients in marine hospitals a study was undertaken to evaluate the redistribution of ward duties to nurses' assistants so as to provide as much additional service as possible economically.* An analysis of nurses' work revealed that a considerable expenditure of time and effort was being made for patient care, clerical routine, and nonprofessional trivia that did not require the attention of a graduate nurse. Bed making, back rubbing, baths, turning and lifting of patients and particularly telephone calls consumed a large portion of the nurse's day unnecessarily.

As subsidiary workers one clerk and one supervising orderly were added to each floor for an experimental period. The floor clerk, located in the office of the charge nurse, was assigned to answering the telephone, compiling reports, checking supplies, assisting with visitors, clerical details of admissions and discharges and other nontechnical functions the performance of which detracts from the nurse's bedside care of patients.

The supervising orderly was assigned to the many duties that usually take attendants from the floor, such as conducting patients in wheelchairs and stretchers, carrying drug baskets, delivery of specimens to laboratories and delivery of laundry and linens. The regular orderlies could then be assigned to additional duties hitherto unnecessarily performed by the graduate nursing staff. Some part of the orderlies' work is supervised by the head orderly.

A similar plan has long been in effect in other hospitals and there is no reason to believe that it will not be equally successful in the marine hospitals.

*Mackenzie, Richard, and Cheney, Bess A.: Report of a Study to Determine Duties That Nurses May Delegate to Orderlies and Other Assistants in Marine Hospitals, *Hospital News*, Jan. 15, 1938. Abstracted by J. Masur, M.D.

Workshops for Tuberculous

The author* discusses the problem of restoring the handicapped individual to gainful employment. He stresses the plight of tuberculous patients who have much in common with those crippled by other ailments. The average tuberculous patient represents a community investment of from \$600 to \$4000 for institutional care. The danger of relapse is greatest during the first three to five years after discharge from an institution. It is almost impossible to procure part-time work for these tuberculous patients under ideal conditions.

The Altro Work Shops, now employing 135 persons, was started in 1915

to provide work for the convalescing tuberculous patient. In these shops, hours are regulated in accordance with the stage of the disease. A live steam method of pressing gives complete hygienic and sanitary conditions of work. Modern machinery and labor-saving devices save workers avoidable physical effort.

Proper rest periods are provided, with facilities both indoors and on the roof for complete relaxation. Lunches are provided at cost. In twenty-five years the patients in Altro have earned more than \$1,420,000. The loss in operation for this period was approximately \$178,000.

During the first ten years 304 patients spent more than three months at the shops, as compared with 580 who spent more than three months during the second decade. Eighty per cent of this second group were in good or fair condition one to ten years later. Of the former group about 50 per cent were in good or fair condition from ten to twenty years later.

The author says that not only does the sheltered workshop help to reduce relapses but it gives the patient a more normal attitude toward his employment and his responsibilities at home.

*Hochhauser, Edward: Preparing Men for Life, Altro Work Shops, Reprinted from *The Crippled Child*, December 1937. Abstracted by Minnie Smith.

Personnel Relationships

The time has now come when more thought and study should be given to developing harmonious relationships among hospital administrators, executives and personnel.* The dietitian is an executive whose duty it is to cooperate with many departments and she also performs the important function of managing personnel.

The desirable and effective method of managing personnel is by leadership. In these days, when many forces seek to undermine authority, a person with leadership is the strongest executive. The qualities of leadership may be developed by training with the will to succeed.

Personnel management begins with the selection of employees to fit the requirements of particular jobs. The interview is important, for the applicant's loyalty and cooperation will be influenced by the impression the executive makes during the interview. Employees should be taught a standard method for each elemental part of their jobs. Interest in maintaining established standards may be developed by noting work well done. The executive should be interested in the welfare as well as the work of the employees. Difficulties should be settled quietly and promptly.

If cooperation is not obtained, it may be the fault of the executive.

*Cooper, Lenna F.: The Human Side of Our Work, *J. Am. Diet. A.*, January 1938. Abstracted by Mary P. McCaffrey.

Hospital Dental Services

The author* emphasizes the need for closer cooperation between the medical and dental professions. He rightly states that the first consideration should be the patient and that dentists, who, after all, deal with medical problems, should have a comprehensive knowledge of the body in general.

The hospital dentist should occupy a respected position on the hospital staff. He should rightfully expect full professional recognition from the hospital and be permitted to participate in its professional activities. The dental chief should be a member of the medical board. The dental department should be equipped adequately to meet the dental needs of the patient.

Adequate funds should be provided by the institution, or through an endowment, for research, current ethical periodicals, a library and routine work. The facilities of the hospital social service department should be available when necessary to avoid competition with practitioners. Careful and accurate records should be kept. Regular staff conferences should be held and the dentists invited to general medical conferences. Opportunity for consultations should be given. Participation in the teaching program is essential. Fellowship subsidies should be awarded to deserving dental interns.

*Masur, J., M.D.: Dental Opportunities in Hospitals, *The Dental Outlook*, March 1938. Abstracted by J. Goodfriend.

Chemicals and Combustion

A study made of effects of chemicals on rate of ignition and combustion of coal, caking and soot deposition, production of smoke and ashes and reaction of chemicals in the fuels, indicates that chemical treatment of coal or coke has little effect on its combustion.*

In the early nineteenth century, large amounts of chemicals were mixed with fuels to speed combustion.

In recent months it has been clearly shown that the effect of a chemical on a ton of coal is directly proportional to the amount of chemical substance used. Too great an amount will smother the fire. Any changes that treatments can make in coal burning decrease in magnitude as the rate of burning increases.

*Unsigned: Effect of Chemical Treatment on Burning Coal, Heating Piping and Air Conditioning, January 1938. Abstracted by Barbara Allen.

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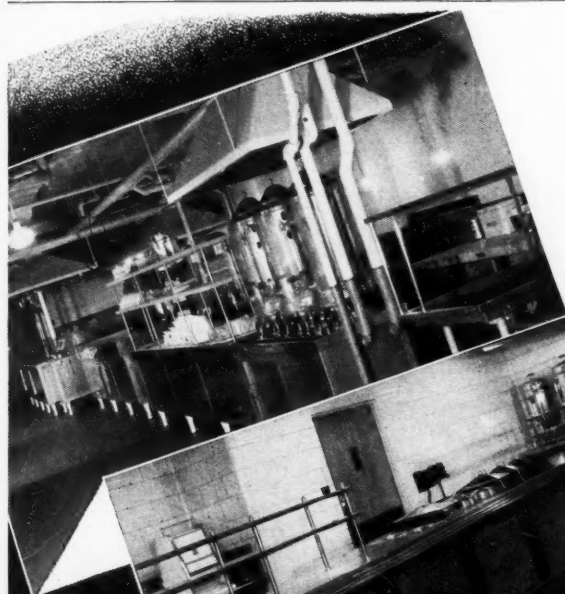
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How to tempt the appetite of a winter-weary patient is often a problem. So here's a suggestion: Serve Kellogg's Corn Flakes. These crunchy, delicious flakes are particularly satisfying at this time of year. Patients welcome their crisp goodness in milk or cream — and they help to revive slumbering appetites.

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BOOKS ON REVIEW

THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES. By *Albert Deutsch*. Garden City, N. Y.: Doubleday, Doran and Co., 1937. Pp. 530. \$2.50.

Occasionally in psychiatric fields a book is written which through sheer force of fact compels an interest strong enough to convert piously phrased hopes of advancement into integrated activity on behalf of the mentally ill. Such a book was the familiar "Mind That Found Itself" of Clifford Beers; such a book, thirty years later, is Albert Deutsch's "The Mentally Ill in America."

Written not with the inherent drama of personal narrative but as a soundly documented and well-indexed historical treatise this volume nevertheless rivals in interest any autobiographical or fictional psychiatric work, simply by marshalling the material which is so amply provided in the story of America's progress from superstition to psychiatry, from extermination of the mentally ill to their humanitarian treatment.

Mr. Deutsch traces these changes in simple, lucid style and indicates clearly their reflection in legislative reforms and in the assumption of new responsibilities by government bodies. However, in his task as social historian he has not neglected the rôle of great individuals and of privately endowed agencies in bringing about those "modern trends," thus lending a hopeful note to the work.

To have collected the facts of this history of progress would in itself have been a notable task, for contained in this volume is material of value to every intelligent person dealing with the various problems of mental illness. To have so presented these facts as not to permit us to rest content with our present gains is a still greater accomplishment. It is this stimulation toward increasing effort, combined with a knowledge of progress already made, that permits us, with the late Dr. William A. White, to "presage wondrous accomplishments for the future." — MINNA EMCH, M.D.

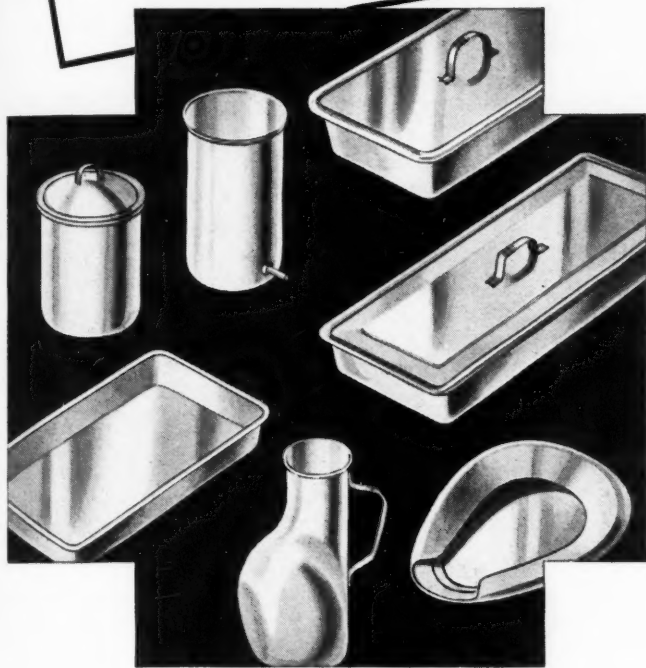
HOW TO HANDLE GRIEVANCES. By *Glenn Gardiner*. New York: Elliott Service Company, 1937. Pp. 52. 45c.

"No employer striving for efficient and profitable returns on his pay roll can any more afford to overlook, neglect or ignore an employe's just cause for dissatisfaction than neglect or ignore the just complaint of a customer!"

Do you as a hospital director know how to listen to grievances, when to reply and what to say? Do you know how to time your decision even though you know what that decision will be before the worker has ended his first sentence? Do you know that your answer should be based not only on logical reasoning but also on psychological reasoning? Do you know that there are several ways of saying, "No," and that the best way will give an explanation accepted by the worker and send him away satisfied?

This little manual gives twenty-five fundamentals of handling grievances and drives each one home with five pertinent comments and a well chosen illustration. A copy should not only be read by every department executive but should be kept in the top drawer of his desk. The hospital that provides these manuals will receive real value for the small outlay required.—GEORGE PECK.

STAINLESS FOR CLEANLINESS



IN WARDS, in operating rooms, in kitchens — everywhere in the hospital — *absolute cleanliness* is the watchword. Hospitals demand materials that can be kept clean, sterile, bright and attractive, with the least possible effort.

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HELP



for "sleep-hungry" patients

A glass of Hot Cocomalt is helping more and more restless, tossing patients to sleep the quiet, drugless, safe way. Leading authorities have found Cocomalt ideal for this hospital use. It is both easily digested and readily assimilated.

And the distinctive flavor of Cocomalt appeals to patients, old and young, alike. Dietetically, it supplies highly desirable food essentials. For example: an ounce-serving of Cocomalt contains .15 gram of Calcium, .16 gram of Phosphorus and to help in the utilization of these food minerals, it also contains 134 U.S.P. Units of Vitamin D, derived from natural oils and biologically tested for potency. Further, each ounce-serving of Cocomalt provides 5 milligrams of effective Iron (biologically tested for assimilation) — $\frac{1}{3}$ of a normal patient's daily "optimum".

Cocomalt—the protective food drink—is inexpensive. It may be obtained at wholesale grocers in the economical 5-lb.

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IRON	0.005 GRAM	*TRACE	0.005 GRAM
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CALCIUM	0.15 GRAM	0.24 GRAM	0.39 GRAM
PHOSPHORUS	0.16 "	0.17 "	0.33 "
PROTEIN	4.00 GRAMS	7.92 GRAMS	11.92 GRAMS
FAT	1.25 "	8.53 "	9.78 "
CARBOHYDRATES	21.50 "	10.97 "	32.47 "

*Normally Iron and Vitamin D are present in Milk in only very small and variable amounts.

†Cocomalt, the protective food drink, is fortified with these amounts of Calcium, Phosphorus, Iron and Vitamin D.

Cocomalt is the registered trade mark of R. B. Davis Co., Hoboken, N. J.

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INVENTED BY A DOCTOR who had been in active practice for over 20 years, Hygeia Nursing Bottle and Nipple have been proved completely sanitary.

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For these reasons and many others, Hygeia magazine advertisements tell mothers 41,000,000 times a month "Safest because easiest to clean. Ask your doctor."

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NEW PRODUCTS

A Young Lady Named Hannah

A highly polished floor is a desirable landscape feature from the esthetic point of view, but to it some people react as to a banana peel. They will go into a skid whether the floor is slippery or not. In fact, there are those who make a fairly lucrative business of purposeful skidding, suing the owner of the floor for damages.

Among the manufacturers of the nonslippery variety of floor wax is the Franklin Research Company. This rubber gloss wax is definitely slip resistant, the company asserts, but it doesn't expect prospective buyers to take its word for it. It offers a compact and handy piece of testing equipment for measuring the frictional resistance of floor wax. This ingenious device permits the buyer to test the slip hazard of floor wax right at his own desk.

A slip test block is available to any commercial user of floor wax upon written request to the company's general office, 5134 Lancaster Avenue, Philadelphia.

Jerry Dies Young

A cocky little germ named Jerry started out to see the world. His mother gave him her blessing and a parting admonition to stay away from hospitals. "For," said she, "many of my friends and relatives have come to an untimely end in those places." Jerry promised to be careful and set out on his way. He traveled far and wide, hopping about from person to person until he decided to settle down in the throat of a man already too well supplied with germs. As a result of the attentions of Jerry and his playmates, the man was taken to the hospital and Jerry, heedless of his mother's warning, went along for the ride. In the hospital he transferred himself from his host's throat to a glass. But that was a mistake. The glass was placed in a machine called a Steri-Scald and Jerry met the fate of his mother's relatives.

The apparatus that caused Jerry's unlamented demise is the product of the Griswold Manufacturing Company, Erie, Pa., and is not intended as a glass washer but as a means of destroying harmful bacteria on drinking glasses and cups, both by chemical action and a scalding spray.

The foundation of Steri-Scald is a patented chlorine cake, which is said to impart a high percentage of chlorine to water passing over it. The average life of one of these cakes is ten days. After the chlorine spray, glasses are sprayed with scalding water (above 170°F.) which, it is claimed, positively removes any trace of the chemical. From three to four seconds is sufficient for the entire operation.

Foiling Jimmy Valentine

Crime does not pay, but you'd never convince some people of the fact. They go right on annexing their neighbors' chattels whenever the chance offers. According to the Segal Lock and Hardware Company, 261 Broadway, New York, however, the chances are going to be very slim what with the invention of a pickproof lock cylinder. It has long been a dogma in the trade that even the most ingeniously devised lock has its Jimmy Valentine, but the Segal Company feels sure that it has now produced the

PRECAUTION



TRADE-MARK

Whenever a surgeon has an unfortunate experience with a faulty instrument, the question arises—"HOW DID IT GET IN HERE?"

If the original request for that instrument did not specify the make desired, no one can blame the buyer for buying on price. No better quality will be purchased than is specified.

WATER NEVER RISES ABOVE ITS SOURCE.

To guard against accidents no instrument should be requested without specifying the maker, and refuse to accept the "just as good."

EVERY SURGEON OWES THIS PRECAUTION TO HIMSELF.

It costs just a little more to have Kny-Scheerer instruments, but they give to the surgeon the assurance he needs to match his skill.

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Asepticrome Surgical Furniture is available in Wheel Stretchers, Solution Stands, Instrument and Dressing Tables, Mayo Instrument Stands, Operators Stools, Instrument and Utility Wall Stands, Anesthesia Tables, Operating Room Foot Stools, Glove Racks, Sponge Racks, Dressing Carriages, Bassinets, Utility Dressing Carriages, Linen Hampers, Irrigator Solution Stands, Kick Buckets, Sponge Receptacles and Circular Instrument Stand.

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every ward and private room should have one.

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No. 160
40 1/2 inches long
27 1/8 inches wide
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Top of platform 3 1/2 inches from floor
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Same except 3 inches narrower

one and only lock likely to prove an exception to this rule.

The cylinder is so constructed as to prevent the opening of the lock by the use of any instrument other than the key that controls it. The new pickproof invention can easily be installed, it is said, merely by replacing the present cylinder. It can be used on filing cabinets, burglary alarms, strong boxes, desks and all types of furniture on which locking devices are used.

Down With Drafts

When the merry little breezes
Whistle 'round your toes
They bring not so merry sneezes
And a redness to the nose.

Which is our own quaint way of pointing out that a draft around one's ankles is bad for the health as well as for the disposition.

The same thought has occurred to others, notably the Ray-Steel Specialties, Inc., of Cleveland. This company has conjured up a clever device called the "Sentry Stop-a-Draft," for the purpose of keeping merry little breezes in their place. This is an air-seal strip made of metal and fabricated material which is attached to the bottom of a door. When the door is closed the air-seal device automatically springs down against the floor, shutting out unwanted air currents. When the door is opened, the strip pops back into the metal channel which encloses it.

The Stop-a-Draft is made to fit standard or special sized doors as required and may be obtained in any one of several finishes to harmonize with your color scheme.

Soap-Saver

How many pushes does it take to make one wash? According to the calculations of Colgate-Palmolive-Peet Company, Newark, N. J., two pushes on the plunger of its new all-metal soap dispenser equals one thorough cleaning up. The dispenser is designed to foil grasping individuals who believe in getting more than their money's worth. Leaning on the plunger doesn't do a bit of good, the mechanism being so designed that only a measured quantity of the soap is released at one time.

The only glass part of the fixture is a little window through which a check of the soap supply can be made, and that is said to be shatterproof.

Colgate will be happy to tell inquirers all about the other features of the dispenser.

Cool, Cooler, Coolest

Tuning in on your favorite temperature is the latest wrinkle in air conditioning pridefully announced by the Delco-Frigidaire Division of General Motors Corporation, Dayton, Ohio. The "Comfort Control" panel, which is built into the top of the new air conditioner, is said to enable the user to regulate the cooling and air circulating services of the unit to his own liking. One may have ventilation without cooling, or cooling with ventilation and the temperature in the room can be regulated from cool to coolest, i.e. from 84° to 72° F. The control panel may also be set to direct the air flow to suit the individual's wishes.

Another feature of the unit is the "Meter-Miser," which upsets all the old theories of the iniquitousness of misers.

"Hospital Sheeting at its Best"

HORCO

Waterproof

RUBBERIZED HOSPITAL FABRICS

The Hospital Preference is Horco

HORCO SHEETINGS are designed solely to withstand the hard usage of hospital measures and to provide a greater degree of comfort and tolerance to the patient.



Buy Rubber Sheeting with "HORCO" trade-mark.

HORCO SHEETINGS are available with Silk, Rayon and Cotton base cloths furnishing to the user a wide range in tensile strengths and selections most economical for any hospital purpose.

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HORCO SHEETINGS can be duplicated in appearance only but the span of serviceability is obtainable through the HORCO method of compounding. HORCO FABRICS can be washed, boiled and even autoclaved a reasonable number of times without injury.

TO PREVENT SUBSTITUTION of materials that are similar in appearance every yard of HORCO is water-marked with the word "HORCO." It is your assurance of the highest grade hospital fabric that will give the greatest service with economy.

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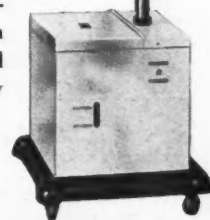
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Mothers learn early the necessity for complete daily sterilizing and careful formula preparation. Doctors' instructions are so much easier to carry out if Pyrex Brand Nursing Bottles are used. They carry a positive two-year replacement offer if broken from sudden temperature changes.

These boil-proof, chill-proof bottles are easy to buy too, because they are known throughout the country. Better drug and department stores everywhere always carry them in regular stock.

Easy to recommend because mothers understand immediately when you say Pyrex Brand Nursing Bottles that they are made of the marvelous heat resistant glass that lasts longer.

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PYREX
 BRAND
NURSING BOTTLES

Against all the rules this miser is a hero who, according to the manufacturer, provides the unit with its cooling and dehumidifying properties with such dependability and efficiency that Frigidaire feels justified in guaranteeing the mechanism for five years.

The installation of the unit, we are told, requires only a connection to a window and to the electric wiring unit.

Dry Bed

All that sheds water is not rubber; a canvas-back duck, for instance. Or take Towertex hospital sheeting which, its maker says, is most definitely not rubber and is equally definitely waterproof. Other advantages claimed for this type of sheeting, by A. J. Tower Company of Boston, are that it is lightweight, but strong and durable; immune to the damaging effects of oil, urine and ordinary sterilizing processes, and can easily be cut and stitched.

Paging New Literature

Hospital Day—Oyez! Oyez! National Hospital Day is coming to town and nobody will be able to doubt it when bumpers, badges, blotters and buttons proclaiming the fact begin to sprout in every direction. Publicity purveyors to the hospitals, The Physicians' Record Company, 161 W. Harrison Street, Chicago, is the source of this material and it is also offering folders and leaflets for distribution. Hospitals interested in the observance of the day are invited to write Physicians' Record for further information.

Light Reading—Imagine how embarrassed a surgeon would be if he was performing an appendectomy and discovered that he had removed the patient's liver because it was too dark for him to see what he was working on. To be sure, the surgeon's embarrassment would be as nothing to the patient's.

Fortunately, those little accidents don't happen in up-to-date surgeries. Or if they do, it isn't because the surgeon can't see. Firms like Scanlan-Morris Company of Madison, Wis., have taken care of that.

An elegant new catalog describes and illustrates such lighting fixtures as the Operay Multibeam and the Surg-O-Ray (both the portable and ceiling model) designed to throw an intense light, glareless and with a minimum of shadow, on the operating field from any height and angle.

Convalescing With Color—Palpitating patients who have been rudely severed from some intimate portion of their anatomy are generally inclined to be glum about the whole thing, particularly during the early period of convalescence. Staring all day long at drab dead-white walls isn't helpful in enlivening one's outlook at such a time. That is why gay interior decoration is becoming increasingly popular.

Comes the United States Gypsum Company, 300 West Adams Street, Chicago, to help the good work of pepping up hospital interiors with water-thinned paints which, the company maintains, save time and money and retain their purity of color.

In a manual entitled "Modern Principles in Paint and Decoration" (a work of art in its own right), U. S. Gypsum seeks to assist would-be purchasers of paints by setting forth the principles of the selection of paints, the proper place to use each type, the preparation of the surface of the walls before painting and their cleaning and maintenance.